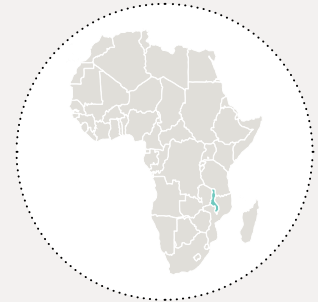


# Malawi

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## Overview

Malawi's most populated areas are the Southern and Central regions. The HIV prevalence in Malawi varies considerably by sex, age, socioeconomic characteristics and geographical location. The HIV prevalence is highest in the Southern Region, which is more densely populated. The areas most affected by HIV, however, are spread across all districts, particularly along major transport routes and commercial, agricultural and/or growing business centres.



## Progress

Important achievements have been made in reducing the number of new infections in Malawi. In a period of four years between 2010 and 2014, the number of people living with HIV and receiving antiretroviral therapy almost doubled. In the rural southern district of Chiradzulu, up to 27 000 people living with HIV (almost 10% of the district population) were receiving antiretroviral therapy by June 2013. A household survey in the same district showed that, despite a 17% HIV prevalence, only 4 new HIV infections for every 1000 residents occurred each year, depicting the best treatment outcomes at the population level documented that had been anywhere in the world and illustrating the preventive effect of antiretroviral therapy.

## Opportunities

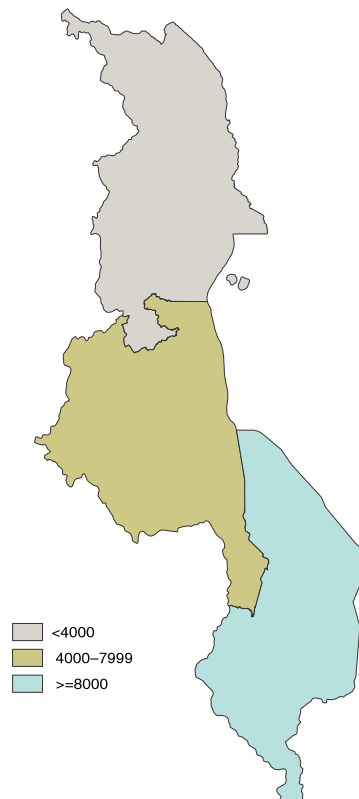
Malawi decentralized antiretroviral therapy and prevention of mother-to-child transmission service provision as early as 2006, taking into account the existing health system realities and constraints (such as health-care staff shortages). Allowing nurses and medical assistants to initiate antiretroviral therapy at the subnational level has contributed significantly to the rapid scale-up. Access to antiretroviral therapy and prevention of mother-to-child transmission services has greatly improved across the country as a result of delivering these services at a variety of clinical settings (including antenatal care, maternity care, under-five clinics, antiretroviral therapy clinics and family planning clinics).

### New infections among women (15–49 years old), 2014

Malawi has recorded a 53% decline in new HIV infections during the past decade. The distribution of new HIV infections is disproportionately higher in the Southern Region compared with the Central and Northern regions. Out of the country's 28 districts, the six districts with the highest number of people living with HIV are found in the Southern Region and account for 42% of Malawi's population. This region has more advanced urban economic centres, as well as major transport routes that cover and connect the region more extensively than those in the Northern Region.

The 2015 PEPFAR Country Operational Plan focuses on the 14 districts with the highest number of people living with HIV, most of which are located in the Southern Region. Other programmes to reduce new HIV infections, including voluntary medical male circumcision, are implemented across the country, with special focus on the 14 priority districts.

A number of partners are implementing programmes for key populations, such as sex workers and men who have sex with men, in alignment with the national strategic plan. However, to improve effectiveness, a mapping exercise for key populations is in the pipeline.

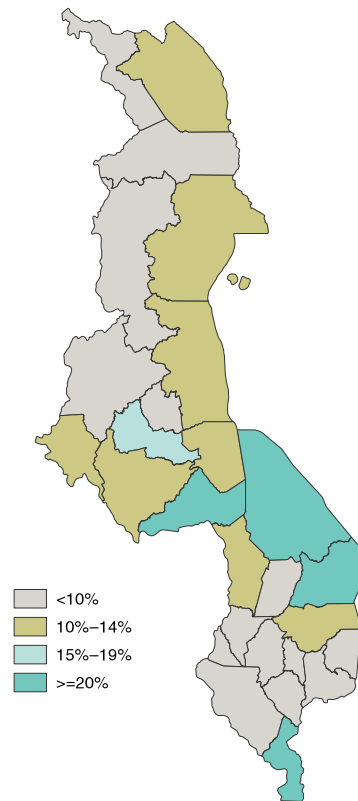


Source: 2014 Malawi estimates.

**Percentage of adult women (15–49 years old) who have discriminatory attitudes towards people living with HIV, 2010**

According to the 2010 Malawi Demographic and Health Survey, women in the Northern and Central regions are more likely to express accepting attitudes towards people living with HIV than women in the Southern Region. Among men, those in the Central Region are more likely to express accepting attitudes than those in the Southern or Northern region.

A national stigma index study is currently underway and will inform a new set of national HIV anti-stigma and discrimination guidelines to address challenges in this area.



Source: 2013 Multiple Indicator Cluster Survey.

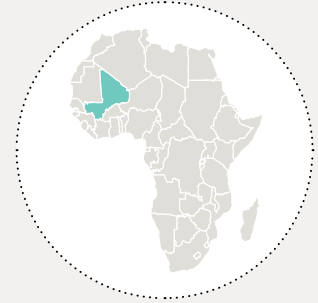
**IN THE PERIOD BETWEEN 2010  
AND 2014, THE NUMBER OF  
PEOPLE IN MALAWI LIVING  
WITH HIV AND RECEIVING  
ANTIRETROVIRAL THERAPY  
ALMOST DOUBLED.**

# Mali

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## Overview

Most of the population in Mali is located in the south-western part of the country. This is also the location of the largest cities. HIV has spread primarily along the trucking routes and thus remains clustered in the southern part of the country.



## Progress

Progress has been made in improving treatment access and preventing children from becoming infected by providing antiretroviral medicines free of charge for people living with HIV and adopting Option B+ for preventing mother-to-child transmission. There is strong high-level political commitment to the HIV response.

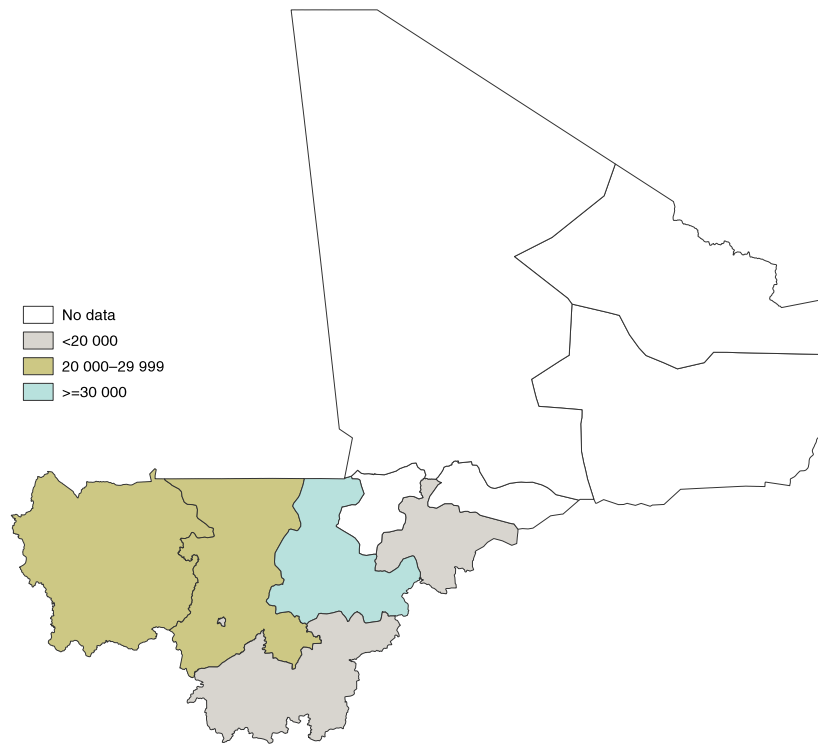
## Opportunities

The need for services is clustered in and around the capital city and other major cities, enabling cost-efficiency in reaching people living with HIV with treatment services and key populations with prevention services.

The decentralization of health services provides opportunities to expand access to HIV services, with all regions of the country having HIV centres. Most HIV centres are located in Bamako, Kayes, Koulikoro, Ségou and Sikasso.

**Number of people living with HIV not receiving antiretroviral therapy, 2014**

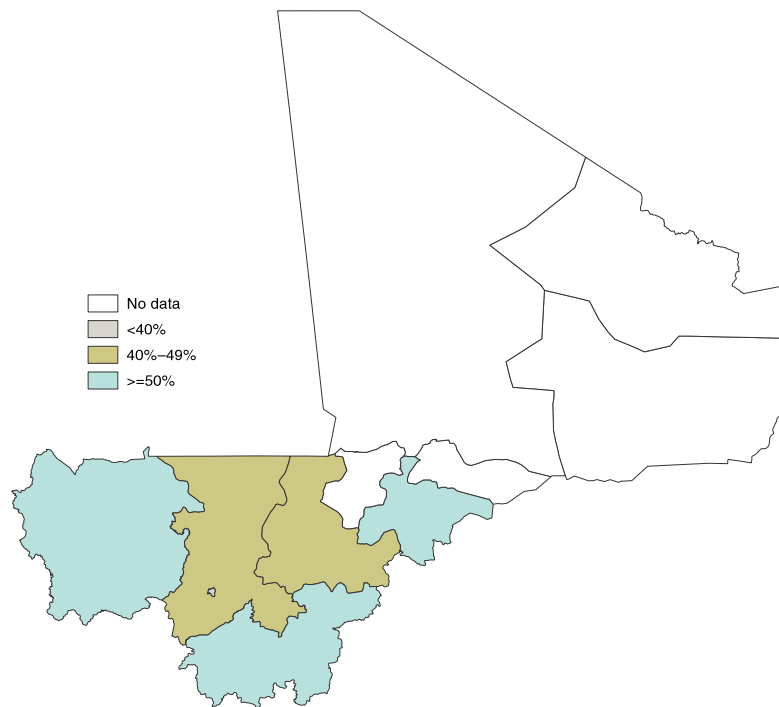
The number of people not receiving antiretroviral therapy is highest in the regions with the highest HIV prevalence. More than 30 000 people living with HIV are not receiving antiretroviral therapy in Ségou region.



Sources: 2014 Global AIDS Response Progress Reporting submission for data on antiretroviral therapy and analysis of the 2012–2013 Demographic and Health Survey for the number of people living with HIV.

**Percentage of people (15–49 years old) who have discriminatory attitudes towards people living with HIV, 2012–2013**

Discriminatory attitudes towards people living with HIV are high across the country. In three regions, more than 50% of the general population reports discriminatory attitudes towards people living with HIV. This is a significant challenge to improving access to prevention and treatment services and promoting a protective environment for the human rights of people living with HIV.



Source: 2012–2013 Demographic and Health Survey.

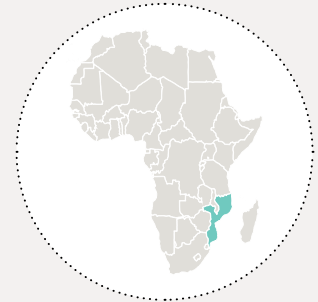
**MOZAMBIQUE HAS RECENTLY  
PASSED A LAW THAT CONFIRMS  
THE RIGHT TO PRIVACY AND  
CONFIDENTIALITY OF HIV STATUS  
AND SPECIFIES THE RIGHTS OF  
SPECIFIC GROUPS OF PEOPLE  
LIVING WITH HIV, INCLUDING  
ORPHANS AND VULNERABLE  
CHILDREN, WOMEN, DISABLED  
PEOPLE LIVING WITH HIV  
AND PRISONERS.**

# Mozambique

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## Overview

Mozambique's most populated areas are the Nampula, Zambezia and Tete provinces. Although the southern region accounts for only one quarter of the population, it is home to 43% of new HIV infections and remains the region with the highest HIV prevalence rates in the country. The South is also where the largest cities and trade corridors to the neighbouring country of South Africa are located.



## Progress

Important progress has been achieved after Mozambique implemented the Accelerated HIV/AIDS Response Plan in 2013, such as focused HIV testing and counselling strategies, and scaling up antiretroviral therapy and Prevention of mother-to-child transmission. The plan is evidence-informed and gives priority to HIV services where they will have greatest impact.

## Opportunities

To reduce the number of new HIV infections, Mozambique still has room to improve HIV diagnosis as well as uptake and retention on treatment, especially for Option B+ and antiretroviral therapy for children, by reinforcing linkages within health facilities and between community and health facilities, improving the quality of services and addressing social and cultural norms.

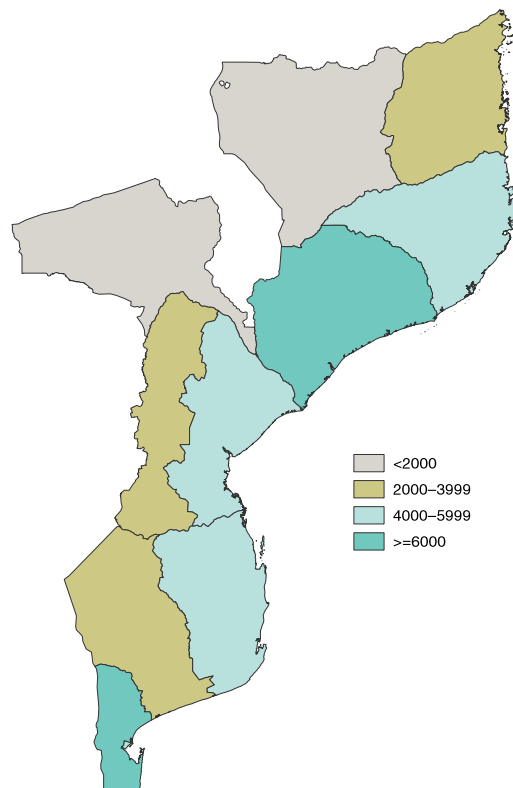
### New infections among women (15–49 years old), 2014

About 90 000 new infections occurred in Mozambique in 2014, 55% of them among women.

The HIV incidence among women is highest in Zambezia and Maputo Provinces as a result of high population mobility to mines and farms in South Africa through trade corridors and of the social and cultural norms that increase women's vulnerability to HIV.

Women in Mozambique acquire HIV earlier and, as a consequence, HIV prevalence is three times higher among women 15–24 years old than it is among men of the same age.

For this reason, the Government of Mozambique has recently recognized girls and young women (10–24 years old) as a priority population for the HIV response. Operationalization plans to address this population are being elaborated and will address social and cultural norms, gender inequality, education and social protection, in addition to biomedical efforts.



Source: 2014 Mozambique estimates.

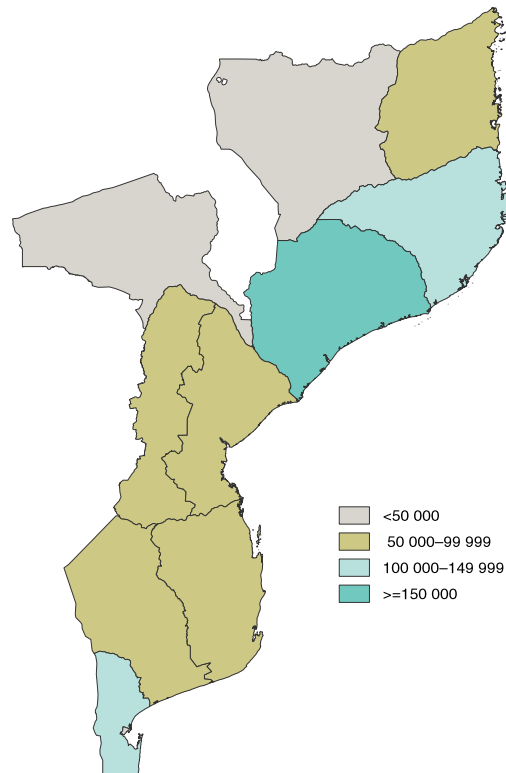
### Number of people living with HIV not receiving antiretroviral therapy, 2014

In Mozambique, 42% [36–56%] of all people living with HIV were receiving treatment in 2014.

The greatest treatment gaps are found in Zambezia and Nampula, which account for 37% of the country's population and are among the locations with the lowest rates of recent HIV testing. There are also many people living with HIV still not receiving treatment in Maputo Province, an area with high HIV prevalence.

To address treatment gaps, the Government of Mozambique has expanded antiretroviral therapy services, especially in Zambezia, where 64% of health facilities now offer antiretroviral therapy services, although challenges remain.

Increasing HIV testing and human resources capacity where major gaps are located and providing treatment at earlier stages of infection might contribute to closing the treatment gaps in Mozambique.



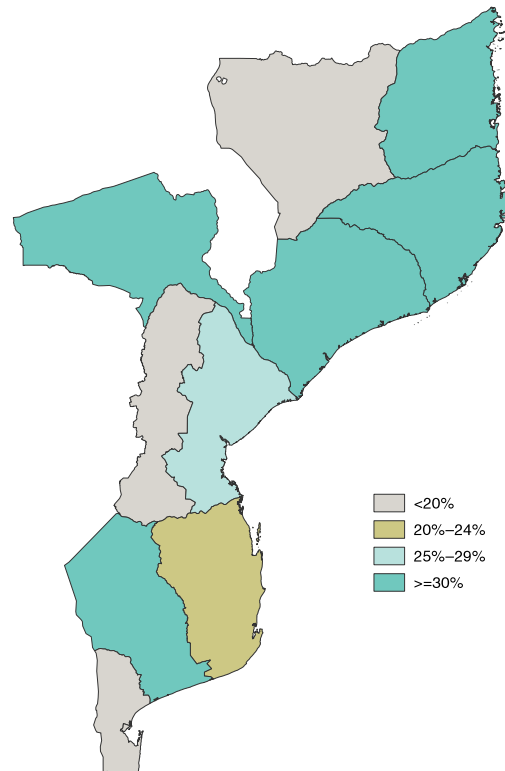
Sources: 2014 Mozambique estimates and 2014 Global AIDS Response Progress Report.

**Percentage of adults (15–49 years old) who have discriminatory attitudes towards people living with HIV, 2011**

Discriminatory attitudes towards people living with HIV vary from 9% in Maputo City to 43% in Cabo Delgado. Nevertheless, discriminatory attitudes remain high throughout the country (28%), and constitute an important barrier for access to HIV services.

In this context, the Government of Mozambique has recently approved Law no. 19/2014 that confirms the right to privacy and confidentiality of HIV status and specifies the rights of specific groups of people living with HIV, including orphans and vulnerable children, women, disabled people living with HIV and prisoners. The law also spells out the responsibilities and rights of health-care professionals with regard to HIV, including those of traditional medicine practitioners.

In addition to the legal framework, national guidelines for integrating HIV prevention, care and treatment for key populations within health facilities are being developed to provide more user-friendly and higher-quality services for these groups.

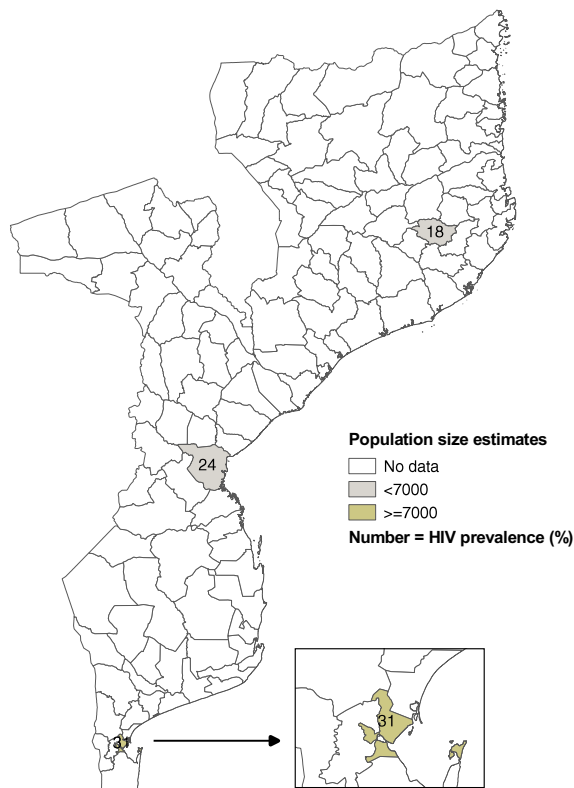


Source: 2011 Demographic and Health Survey.

**Female sex workers: population size estimate and HIV prevalence, 2012**

The HIV prevalence among female sex workers was very high in the three sites where it was measured: Beira, Maputo and Nampula. The estimated number of women selling sex in each city suggests a high burden of disease.

Recognizing the health needs as well as vulnerability to HIV of female sex workers, the Ministry of Health is planning to establish 22 key population-friendly health facilities throughout the country where treatment will be made available for female sex workers and men who have sex with men living with HIV, regardless of CD4 count.



Source: Inquérito integrado biológico e comportamental entre mulheres trabalhadoras de sexo, Moçambique 2011–2012 relatório final (<http://globalhealthsciences.ucsf.edu/gsi/IBBS-MTS-Relatorio-Final.pdf>).

**INCREASING HIV TESTING AND  
HUMAN RESOURCES CAPACITY  
WHERE MAJOR GAPS ARE  
LOCATED AND PROVIDING  
TREATMENT AT EARLIER  
STAGES OF INFECTION  
MIGHT CONTRIBUTE TO  
CLOSING THE TREATMENT  
GAPS IN MOZAMBIQUE.**

# Myanmar

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## Overview

Five of the 15 states and regions in Myanmar make up 60% of the total population. These states are primarily in the central part of the country. The HIV epidemic in Myanmar is concentrated among men who have sex with men, people who inject drugs and female sex workers. Most HIV and AIDS cases are reported from large urban areas, and from the north-eastern and northern areas of the country where injecting drug use is widespread.



## Progress

There has been impressive scale-up in the numbers of people receiving treatment. Patients enrolled in antiretroviral therapy at public sites have increased from 12 692 in 2011 to 40 617 in 2013. In 2014, 18 947 new patients were started on antiretroviral therapy compared to 5146 in 2011. Retention in care of people on antiretroviral therapy at 12 months was 82%, and 78% at 24 months. HIV–TB collaboration was strengthened. HIV prevalence among new TB patients has decreased from 11.1% to 8.5%. HIV testing and counselling as the entry point into the continuum of care has been scaled up from 95 851 tests in 2012 to 666 752 in 2014. Testing among key populations has increased. There have been increases in needle and syringe programmes and methadone programmes for people who inject drugs.

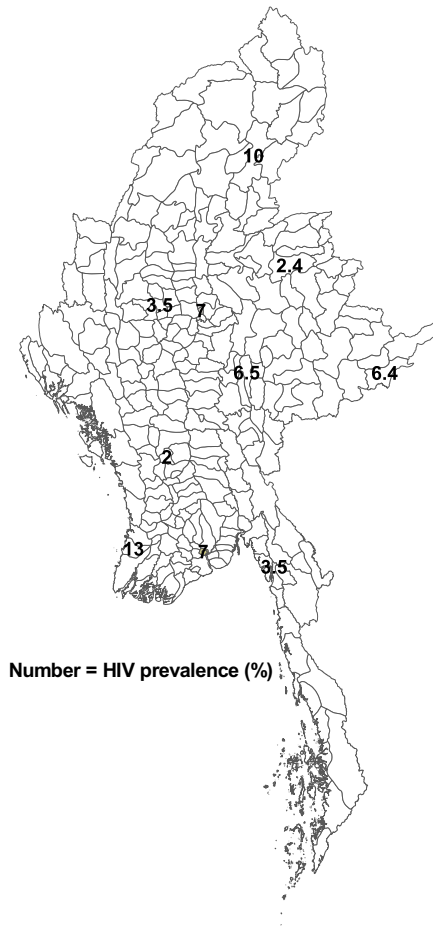
Care and support for people living with HIV is provided through nine national civil society networks. To meet the needs of migrants and mobile populations, cross-border collaboration is being strengthened. The review of restrictive laws impeding access to HIV prevention, care and treatment services, especially for key populations, has been initiated.

## Opportunities

Building on the achievements and lessons learned from the past national strategic plans, the 2016–2020 plan will Fast-Track the response, working closely with key stakeholders, including civil society and affected communities, to focus on the locations, people and programmes that will deliver the greatest impact. HIV testing and counselling will be promoted through both facility- and community-based model, prompt HIV treatment for people living with HIV will be offered upon HIV diagnosis, and access to viral load testing will be expanded. HIV-related services will be integrated with other diseases.

**Female sex workers: HIV prevalence, 2014**

HIV prevalence among female sex workers was measured in 10 sentinel sites. The highest prevalence is noted in the south-west and the far North of Myanmar. Prevention, care and treatment services for female sex workers are distributed across the states and regions with emphasis on the mentioned sentinel sites.



Source: 1) Results of HIV sentinel sero-surveillance, 2014, Myanmar. National AIDS Programme, Department of Health (draft report 2014).

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**Men who have sex with men: HIV prevalence, 2014**

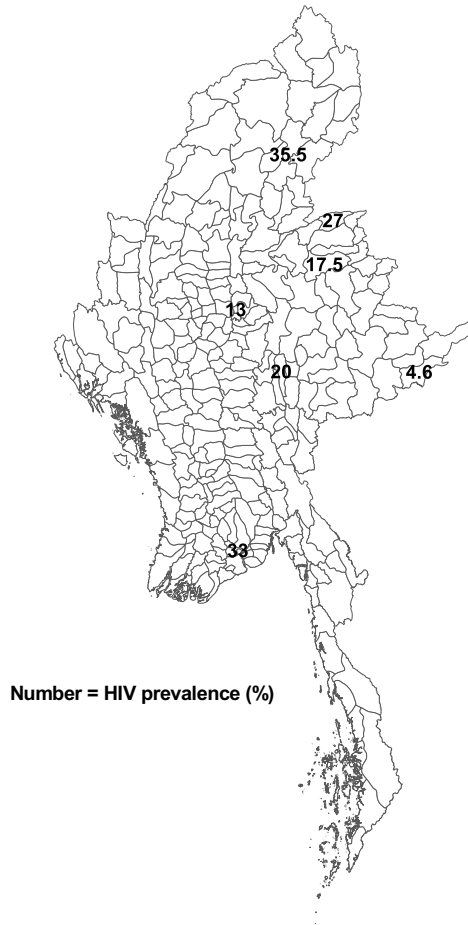
HIV prevalence among men who have sex with men is the highest in the southwest. Prevention, care and treatment services for men who have sex with men are distributed across states and regions with emphasis on the sentinel sites.



Source: 1) Results of HIV sentinel sero-surveillance, 2014, Myanmar. National AIDS Programme, Department of Health (draft report 2014).

**People who inject drugs: HIV prevalence, 2014**

HIV prevalence among people who inject drugs is highest in the Yangon area and the northern and north-east regions near the Chinese border. Prevention, care and treatment services for people who inject drugs are distributed in the most affected regions of the country based on sentinel sites information.



Source: 1) Results of HIV sentinel sero-surveillance, 2014, Myanmar. National AIDS Programme, Department of Health (draft report 2014).

# Namibia

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## Overview

Namibia has the second lowest population density in the world. The north-central and north-eastern parts account for 60% of the population. Two thirds of the population lives in rural areas. Namibia is an upper-middle-income country, but its income distribution is among the most unequal in the world.



## Progress

Important achievements have been made in reducing the number of new infections in the country through outreach to rural communities and growing informal settlements around the cities, as well as special programmes addressing sex workers and other vulnerable populations (such as truck drivers).

Namibia's antiretroviral therapy programme has been its flagship achievement. The coverage of services for Prevention of mother-to-child transmission exceeds 95%, among the highest in the world, and AIDS-related deaths have been drastically reduced.

A combination prevention strategy has been developed to support the implementation of the revised national HIV strategy. The government has demonstrated significant political commitment by providing more than 60% of the AIDS response budget in a context of decreasing external resources.

## Opportunities

The revised national strategy now has adequate provisions to reach people with disabilities and key populations, and to address widespread stigma and discrimination, gender violence and legal barriers that continue to impede the realization of human rights, HIV prevention and health-care access among key populations.



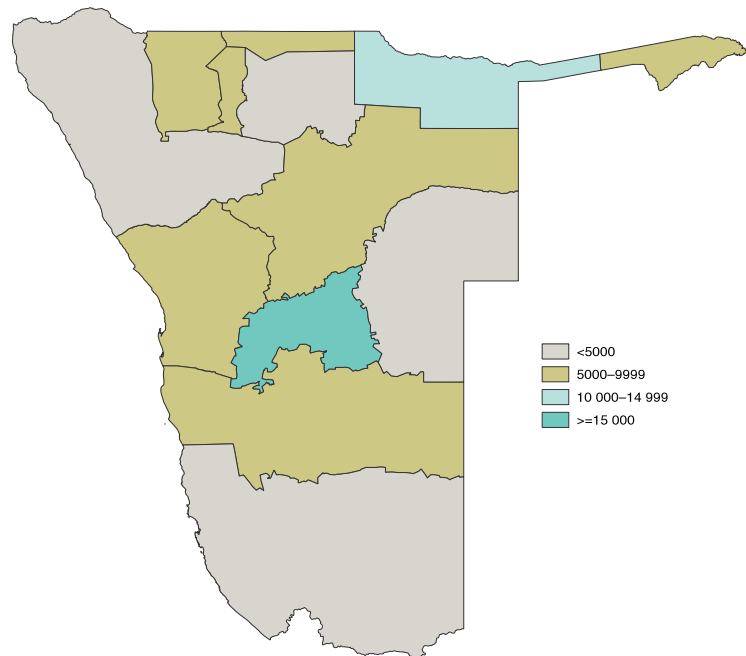
**Number of people living with HIV not receiving antiretroviral therapy, mid-2015**

The number of people living with HIV is highest in the central and northern regions. The number of people living with HIV and not receiving antiretroviral therapy is highest within the same regions. As depicted in the map, the Khomas and Kavango regions have the highest number of people living with HIV not receiving antiretroviral therapy.

In Khomas Region, rural-to-urban migration has created vast informal settlements around the city of Windhoek. Public utilities are limited within these settlements, and alcohol and drug abuse is highly prevalent. There are many people living with HIV in these communities who do not know their status, and treatment dropout rates are high. In the north-eastern regions such as Kavango, Zambezi and, Ohangwena, Omusati and Oshana, which border Angola, the population is extremely fluid between the two countries, creating difficulty for treatment programmes when following-up with clients. Dropout rates are also high, and adherence to antiretroviral therapy is difficult to monitor.

The Ministry of Health and Social Services has started implementing a treat all policy, with a commitment to improving adherence, particularly in these high-impact regions.

Civil society can make an important difference in further antiretroviral therapy increasing coverage and sustaining treatment adherence, especially in remote communities.



Sources: 2014 Namibia estimates and Global AIDS Response Progress Report mid-2015.

**CIVIL SOCIETY CAN MAKE  
AN IMPORTANT DIFFERENCE  
IN FURTHER INCREASING  
ANTIRETROVIRAL THERAPY  
COVERAGE AND SUSTAINING  
TREATMENT ADHERENCE,  
ESPECIALLY IN REMOTE  
COMMUNITIES.**



**NAMIBIA'S ANTIRETROVIRAL THERAPY PROGRAMME HAS BEEN ITS FLAGSHIP ACHIEVEMENT. THE COVERAGE OF SERVICES FOR PMTCT EXCEEDS 95%, AMONG THE HIGHEST IN THE WORLD, AND AIDS-RELATED DEATHS HAVE BEEN DRASTICALLY REDUCED.**

# Nigeria

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## Overview

Nigeria has a very high population density, with most of the population living along the southern coast, in the south-west and in the far North. The HIV prevalence is highest in the southern coast regions and lowest in the south-eastern region.



## Progress

The number of HIV testing and counselling sites increased eightfold between 2010 and 2014. The number of sites offering antiretroviral therapy services has more than doubled. Specific efforts have been made to reach young people and key populations at increased risk of acquiring HIV with behaviour change and communication strategies.

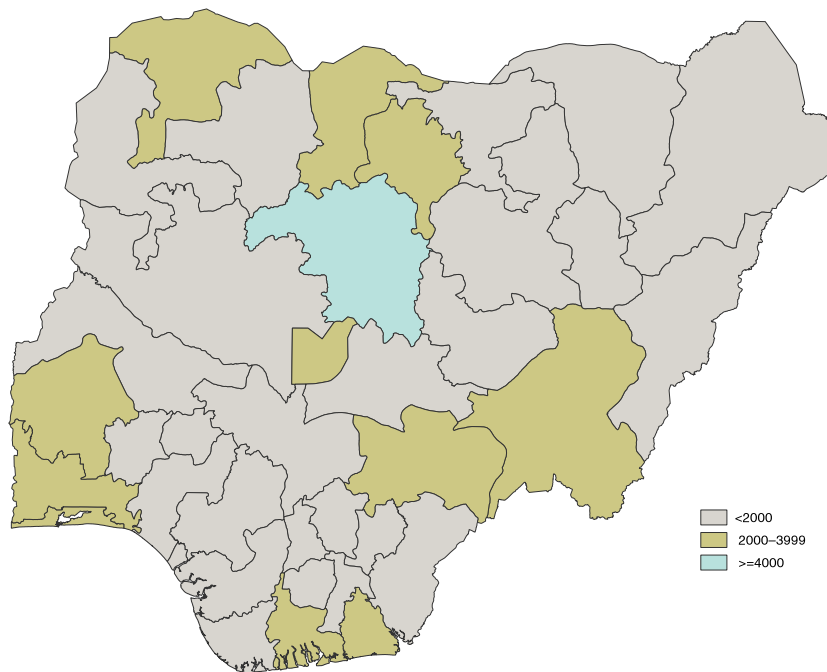
## Opportunities

A renewed effort by Nigeria and development partners to focus the HIV response on the states with the highest burden of HIV infection has the potential to markedly improve the HIV response in Nigeria. Several challenges remain because of the sheer size, volume and coordination required for the HIV response in such a diverse country.

**New infections among women (15–24 years old), 2014**

The number of women 15–24 years old newly infected with HIV is highest in Kaduna State, a state with high prevalence overall. The number of women 15–24 years old newly infected is also large in some central, southern and south-western states, as well as in northern states, including Katsina, Kano and Sokoto.

Programmes to ensure that young women have the information they need to protect themselves are underway using the Family Life and HIV Education training curriculum.

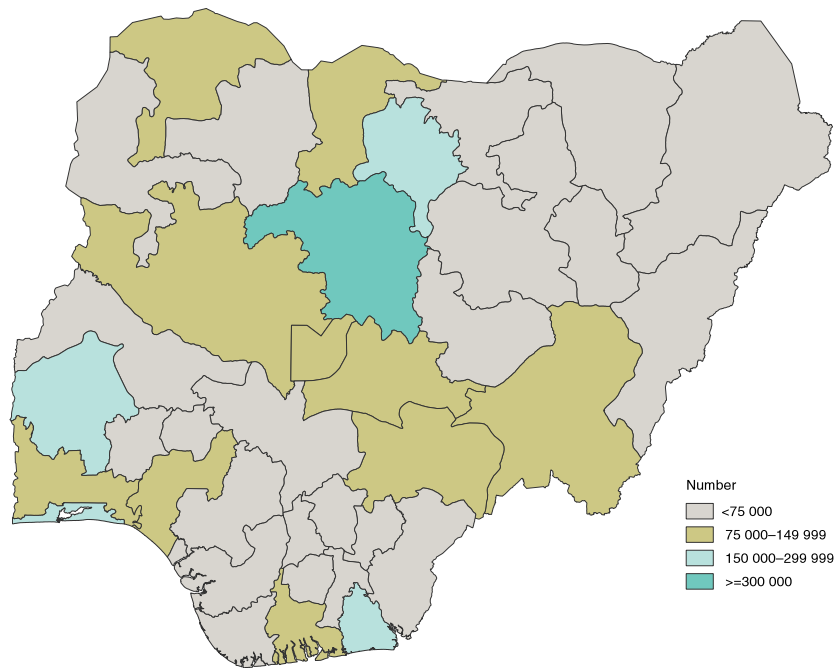


Source: 2014 Nigeria preliminary subnational estimates.

**Number of people living with HIV not receiving antiretroviral therapy, 2014**

Although important gains have been made in reaching individuals with antiretroviral therapy, many people living with HIV are not receiving treatment. More than 300 000 people living with HIV in Kaduna State are not receiving treatment.

The scale-up of antiretroviral therapy services has moved from being mostly based in tertiary hospitals to secondary and even some primary health-care facilities. Over the years, the government has initiated the decentralization of antiretroviral therapy services to the primary health-care level to increasing access to antiretroviral therapy. This decentralization process designates primary health-care centres as antiretroviral therapy refill centres and integrates the delivery of this service into the routine of health-care workers already employed there. Nurses and community health workers at these primary health-care facilities do not initiate antiretroviral therapy but perform rapid HIV screening and can also provide support services for those already initiating antiretroviral therapy.

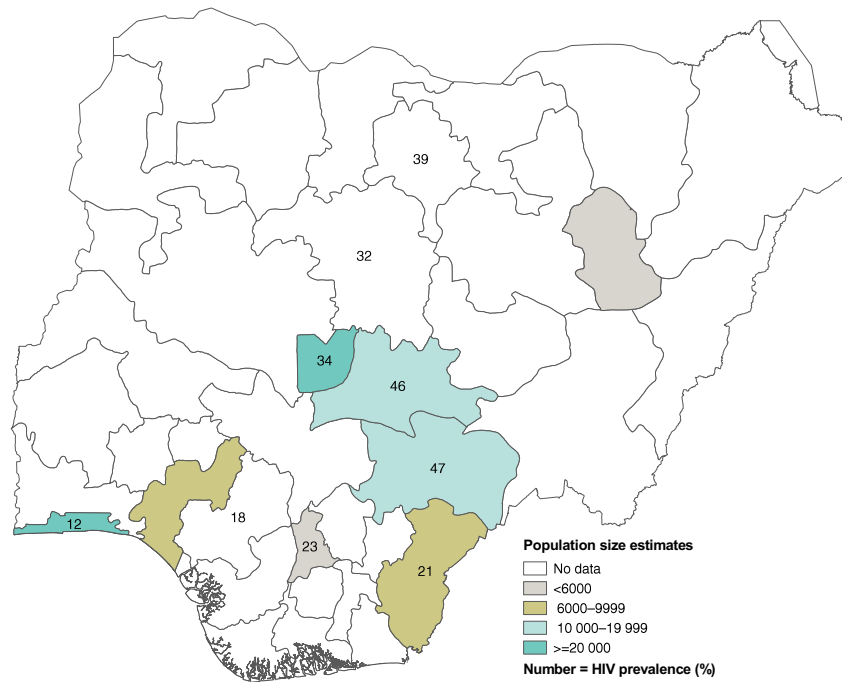


Source: 2014 Nigeria preliminary subnational HIV estimates.

**Female sex workers: population size estimate and HIV prevalence, 2010**

The HIV prevalence among female sex workers is very high in all states where measured. The numbers of sex workers across states are also large, suggesting a very high burden borne by these women.

To respond to recent findings that condom use was decreasing among sex workers, gender-sensitive prevention actions were intensified to address higher-risk behaviour among men. The changing dynamics of transactional sex are being challenged through behaviour change and communication efforts focusing on girls and young people. Programming for condom use is also being enhanced among female sex workers and their communities, including among clients of sex workers.

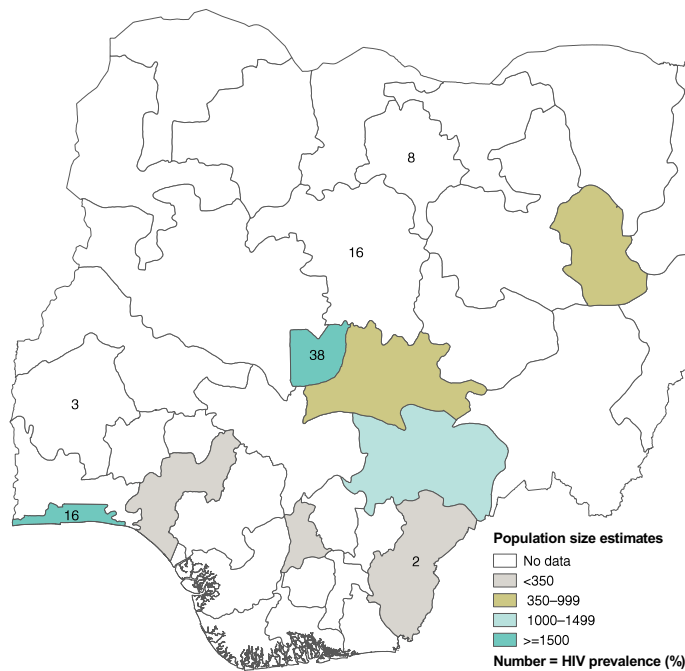


Sources: HIV/STI Integrated Biological and Behavioural Surveillance Survey (IBBSS), 2010. Abuja: Federal Ministry of Health; 2010 ([http://www.popcouncil.org/uploads/pdfs/2011HIV\\_IBBSS2010.pdf](http://www.popcouncil.org/uploads/pdfs/2011HIV_IBBSS2010.pdf)); Ikpeazu A et al. An appraisal of female sex work in Nigeria—implications for designing and scaling up HIV prevention programmes. PLoS One. 2014;9: e103619 (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4131880>).

**Men who have sex with men: population size estimate and HIV prevalence, 2010**

HIV prevalence is very high in Abuja and Lagos, where many men who have sex with men reside.

The national strategic plan emphasizes behaviour change communication for HIV prevention among populations at higher risk. The programme uses social networking approaches to reach hidden and stigmatized groups and establishes referral systems to health services in clinics friendly to populations at higher risk. Specialized training and capacity-building friendly to populations at higher risk are conducted for private and public sector health-care providers as well.

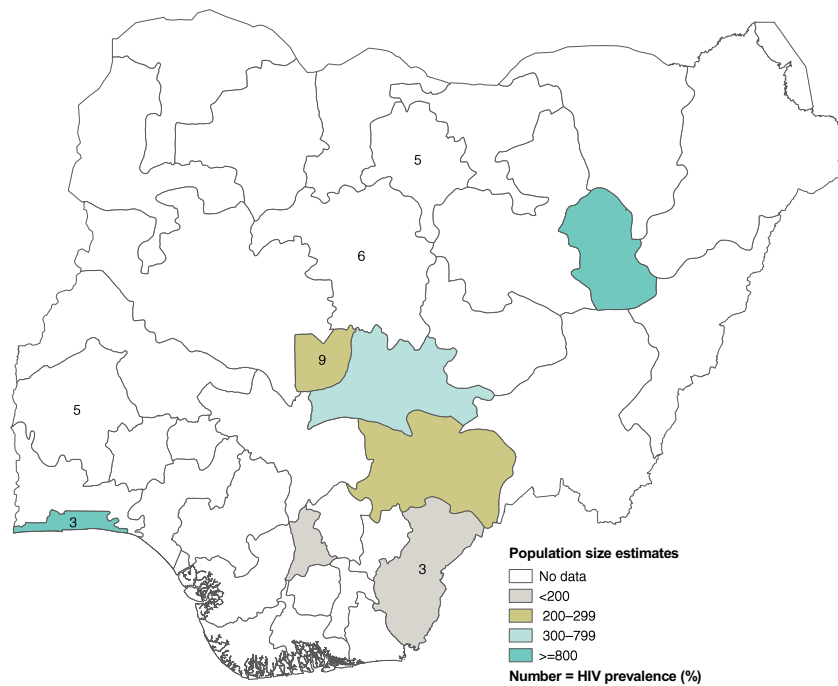


Sources: HIV/STI Integrated Biological and Behavioural Surveillance Survey (IBBSS), 2010. Abuja: Federal Ministry of Health; 2010 ([http://www.popcouncil.org/uploads/pdfs/2011HIV\\_IBBSS2010.pdf](http://www.popcouncil.org/uploads/pdfs/2011HIV_IBBSS2010.pdf)); HIV epidemic appraisals in Nigeria: evidence for prevention programme planning and implementation—data from the first eight states. Abuja: National Agency for the Control of AIDS; 2013 ([http://sbccvch.naca.gov.ng/sites/default/files/Local%20Epidemic%20Appraisal\\_glossy%20report.pdf](http://sbccvch.naca.gov.ng/sites/default/files/Local%20Epidemic%20Appraisal_glossy%20report.pdf)).

**People who inject drugs: population size estimate and HIV prevalence, 2010**

Injecting drug use remains relatively rare in Nigeria but is present, and people who inject drugs have important prevalence levels.

The widespread availability of sterile needles and syringes at pharmacies and patented medicine stores makes needle sharing less of a major route of HIV transmission among people who inject drugs in Nigeria. However, no active national HIV programme is targeting people who inject drugs.



Source: HIV/STI Integrated Biological and Behavioural Surveillance Survey (IBBSS), 2010. Abuja: Federal Ministry of Health; 2010 ([http://www.popcouncil.org/uploads/pdfs/2011HIV\\_IBBSS2010.pdf](http://www.popcouncil.org/uploads/pdfs/2011HIV_IBBSS2010.pdf)); HIV epidemic appraisals in Nigeria: evidence for prevention programme planning and implementation—data from the first eight states. Abuja: National Agency for the Control of AIDS; 2013 ([http://sbccvch.naca.gov.ng/sites/default/files/Local%20Epidemic%20Appraisal\\_glossy%20report.pdf](http://sbccvch.naca.gov.ng/sites/default/files/Local%20Epidemic%20Appraisal_glossy%20report.pdf)).

# Pakistan

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## Overview

The majority of the population in Pakistan live in the eastern and northern regions of the country. Pakistan's HIV epidemic has been characterized primarily by transmission through injecting drug use but is increasingly characterized by sexual transmission. Although some prevention programmes have been implemented, the use of sterile injecting equipment and condom use continue to be low among people who inject drugs. Condom use is especially low among sex workers, in particular among male and hijra sex workers. The majority of key populations in Pakistan are located in five major cities.



## Progress

Important achievements have been made in the allocation of domestic resources to the HIV response and securing funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Treatment services have been scaled up and outreach to people who inject drugs, sex workers and other key populations has been expanded.

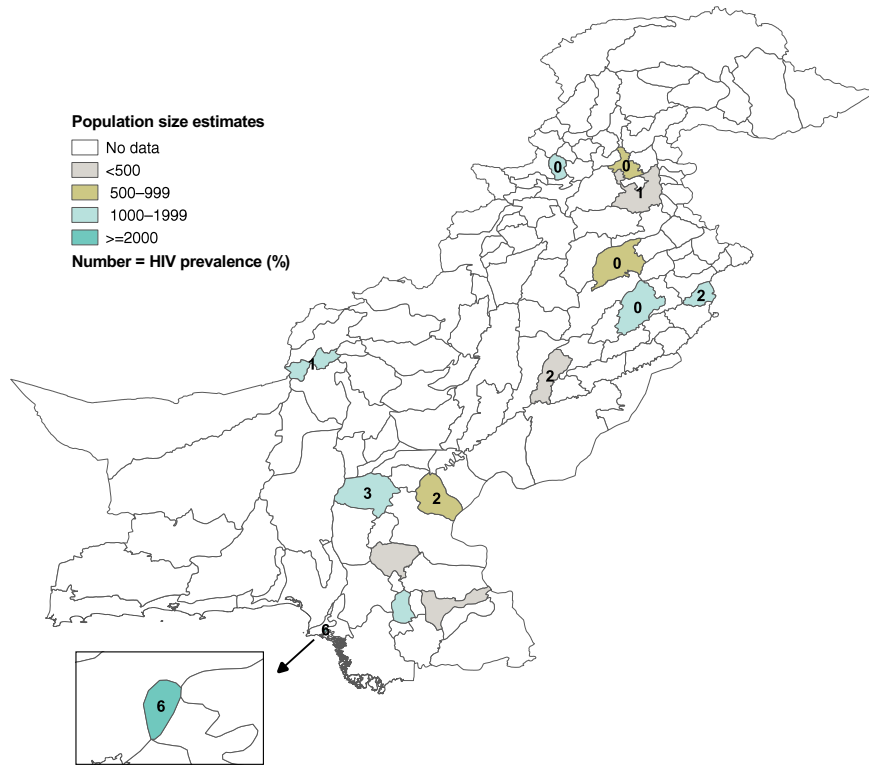
## Opportunities

Prevention efforts focused on the populations and locations, including major cities, that have been most severely affected by the epidemic are required to minimize HIV transmission and curtail the epidemic.



**Male sex workers: population size estimate and HIV prevalence, 2011**

Male sex workers work throughout Pakistan. The HIV prevalence remains low among male sex workers, but prevention services are still needed. The highest numbers of male sex workers were estimated in Karachi, followed by Larkana.

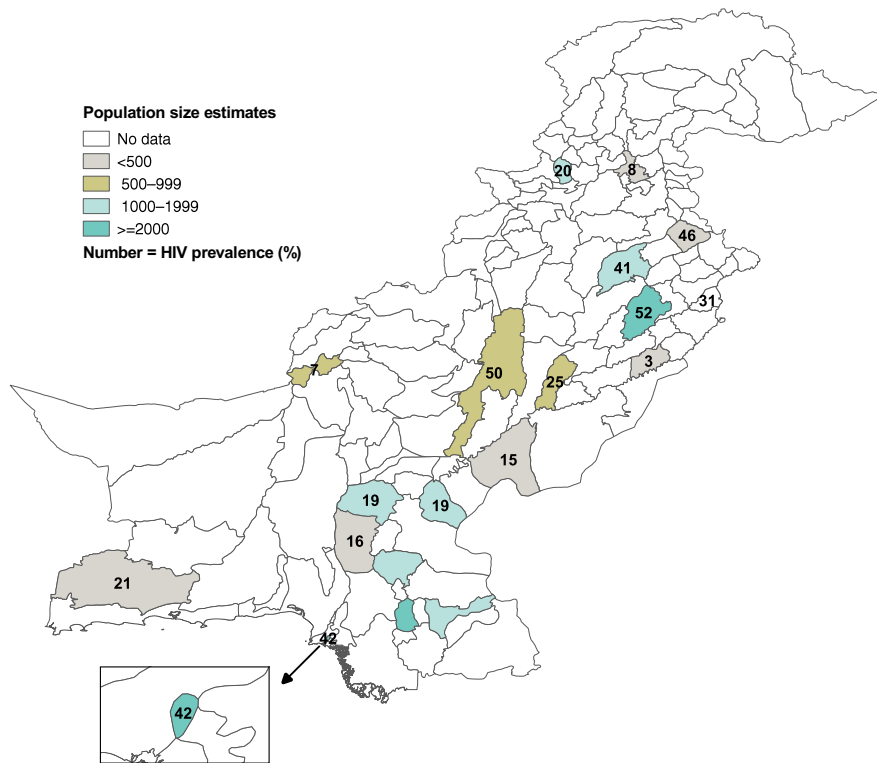


Sources: HIV second generation surveillance in Pakistan: national report round IV, 2011 (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3841725>) and HIV-AIDS surveillance project. Mapping of key populations at risk of HIV. HIV second generation surveillance in Pakistan. Islamabad: National AIDS Control Program, Government of Pakistan; 2012.

**People who inject drugs: population size estimate and HIV prevalence, 2011**

People who inject drugs are found throughout Pakistan, with some larger communities in the central and eastern part of the country, near Gujrat and Faisalabad. More than half the people who inject drugs around Faisalabad are living with HIV. Harm-reduction programs for people who inject drugs need to be readily accessible in all provinces of Pakistan, with a focus on the priority provinces.

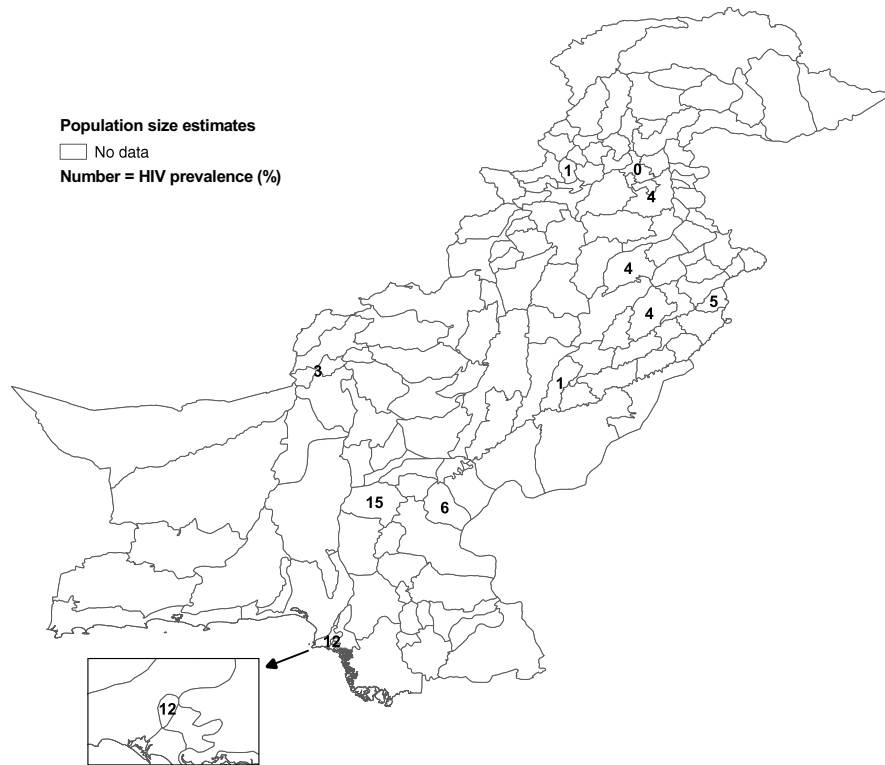
The future of the HIV epidemic in Pakistan will depend on the scope and effectiveness of HIV prevention programmes for people who inject drugs and their sexual partners, as well as sex workers and their clients.



Sources: HIV second generation surveillance in Pakistan: national report round IV, 2011 (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3841725>) and HIV-AIDS surveillance project. Mapping of key populations at risk of HIV. HIV second generation surveillance in Pakistan. Islamabad: National AIDS Control Program, Government of Pakistan; 2012.

**Transgender people: population size estimate and HIV prevalence, 2011**

HIV prevalence among transgender people is heterogeneous. The HIV prevalence suggests that Larkana and Karachi have an important need for programmes to prevent infections among transgender people.



Sources: HIV second generation surveillance in Pakistan: national report round IV, 2011 (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3841725>) and HIV-AIDS surveillance project. Mapping of key populations at risk of HIV. HIV second generation surveillance in Pakistan. Islamabad: National AIDS Control Program, Government of Pakistan; 2012.

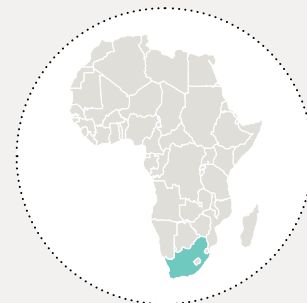
**TREATMENT SERVICES IN  
PAKISTAN HAVE BEEN SCALED UP  
AND OUTREACH TO PEOPLE WHO  
INJECT DRUGS, SEX WORKERS  
AND OTHER KEY POPULATIONS  
HAS BEEN EXPANDED.**

# South Africa

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## Overview

About 54% of South Africa's population of 52 million people lives in three provinces: Gauteng, KwaZulu-Natal and Eastern Cape. South Africa has the largest HIV epidemic in the world, with an estimated 6.8 million [6.5 million–7.5 million] people living with HIV, of which 3 million are accessing antiretroviral therapy. The country has the third-highest tuberculosis incidence in the world, and about 62% of the people with tuberculosis are living with HIV. The HIV epidemic is heterogeneous within provinces, and an effective response is being developed through localization. South Africa has also made tremendous progress in reducing mother-to-child transmission of HIV.



## Progress

Political commitment, domestic funding and the scale and quality of HIV and tuberculosis services have increased dramatically. South Africa has the largest number of people on antiretroviral therapy worldwide, with more than 3 million people receiving treatment as of mid-2015. HIV prevention programmes have also gained pace. According to the 2012 household HIV prevalence survey, 65% of South Africans had been tested for HIV, and HIV testing and counselling services are perceived as highly accessible. A massive condom promotion campaign is ongoing, and about 2 million voluntary medical male circumcisions have been carried out since 2010.

The benefits are increasingly evident. HIV treatment expansion in South Africa has saved the lives of an estimated 1.3 million people since 1995. The 2012/2013 MRC evaluation of the national prevention of mother-to-child transmission programme effectiveness found that the HIV transmission to infants at six weeks postpartum decreased. According to the latest government development indicators report, life expectancy increased from 52 years in 2004 to 61 years in 2014, and infant mortality dropped from 58 to 29 deaths per 1000 live births between 2002 and 2014 (Rapid Mortality Surveillance, Medical Research Council).

## **Opportunities**

The gains also highlight the enormous efforts that are still needed to overcome South Africa's HIV epidemic. Because of the life-saving benefits of treatment, the total number of people living with HIV is rising, which underscores the need for more effective prevention efforts. Women (especially young women and girls) face inordinate risks of acquiring HIV, which calls for a more effective enabling environment.

Programmes need to be tailored to the differing needs of groups at higher risk in locations with a high burden of HIV infection. HIV testing and counselling campaigns need to reach young people and men, who have significantly lower testing rates. To move closer to the 80% coverage target for voluntary medical male circumcision by 2016, scaling up voluntary medical male circumcisions will require creating increased demand at the community level and engaging traditional leaders around integrating male medical circumcision into traditional practices.

Renewed social marketing of condoms is critical to increase condom use, especially among people 15–24 years old. To reduce the number of women newly infected with HIV, especially adolescent girls and young women, appropriate packages of combination services need to be saturated in locations with a high burden of HIV infection for these women and their male sex partners.

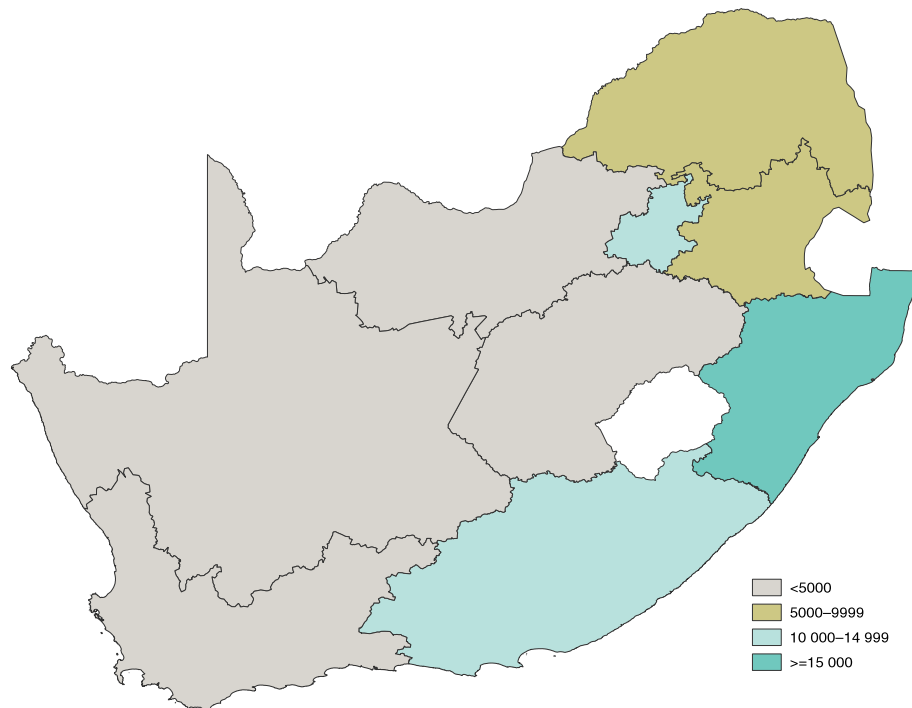
**New infections among women (15–24 years old), 2014**

Young women 15–24 years old are up to eight times more likely to be living with HIV than their male peers. In 2014, most young women 15–24 years old newly infected with HIV lived in KwaZulu-Natal, Gauteng and Eastern Cape provinces.

KwaZulu-Natal accounts for more than 15 000 of the 72 000 women 15–24 years old newly infected annually. In response, the KwaZulu-Natal provincial government runs an innovative, integrated multisectoral service delivery model. Through this people-centred approach, services are taken closer to the people through targeted service delivery in specific areas, such as transport routes where key populations are located and taxi ranks.

Much more needs to be done to improve prevention efforts, especially for young women. Other risk-enhancing factors (including alcohol abuse, violence against women and socioeconomic insecurity) require concerted action.

Attention should to be given to mobility and migration, including internal migration between rural and urban settings and cross-border migration.



Source: 2014 South Africa preliminary subnational estimates.



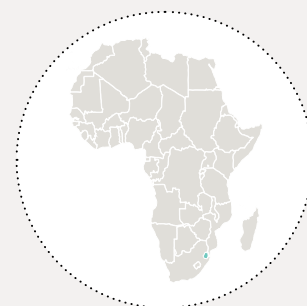
# Swaziland

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## Overview

The population of Swaziland is fairly evenly distributed across the country, with the largest city located in Manzini province in the central-west part of the country. About 49% of the population in Swaziland is younger than 20 years. Women, men who have sex with men and sex workers are disproportionately affected by HIV.

The country is divided into four administrative regions: Hhohho, Lubombo, Manzini and Shiselweni. Manzini region is the most populous, with more than 30% of the population, followed by Hhohho region with 28% of the population. The estimated HIV prevalence is similar across the four regions, although the numbers of people living with HIV differ. Anecdotal evidence suggests that the areas most affected by HIV are mainly major urban centres, cross-border points and towns around major transport and trade corridors. Key among these is the southern transport corridor between the cities Mbabane and Manzini.



## Progress

Although the HIV incidence has decreased, it is still high. Several HIV prevention programmes have been implemented, with increased coverage in HIV testing and counselling from 147 facilities in 2010 to 264 in 2013. The percentage of people tested and counselled in the past 12 months increased between 2010 and 2014. Scale-up of male circumcision was initiated in 2008, resulting in improved uptake. However, condom use has declined among women 15–49 years old, with a reduction in knowledge levels among people 15–24 years old.

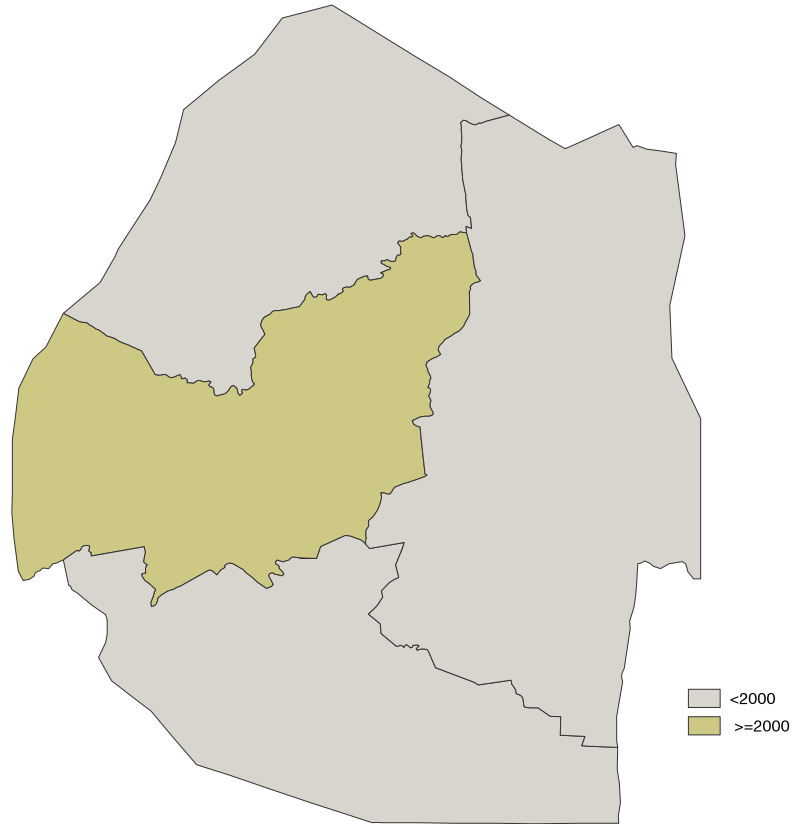
The country has shown significant progress in reducing new infections among children and in antiretroviral therapy. The number of people receiving antiretroviral therapy has increased, and retention in care at 12 months has increased among both adults and children. According to the 2012 Swaziland HIV Incidence Measurement Survey, 85% of people living with HIV who reported receiving antiretroviral therapy were virally suppressed.

## Opportunities

HIV services are clustered in urban areas, although about 70% of the population lives in rural areas. Although people living with HIV are concentrated in urban areas, service availability needs to be revisited and reviewed to ensure that these areas have the greatest needs. A geospatial analysis at the subregional level on the epidemic and response is underway.

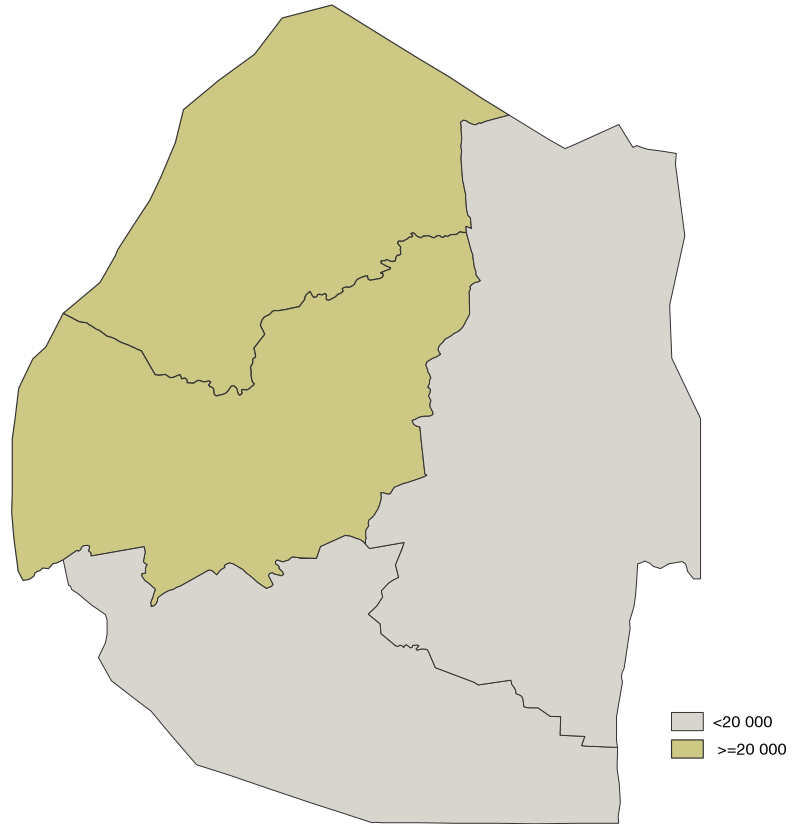
**New infections among women (15–49 years old), 2014**

The largest number of people living with HIV is estimated to be in the Manzini region. Manzini is also the region with the highest estimated number of new HIV infections among young women 15–24 years old. Most health facilities in the country are located in Manzini. Efforts are underway to continually review and redirect programmes to reduce new HIV infections.



Source: 2014 Swaziland estimates.

**Number of people living with HIV not receiving antiretroviral therapy, mid-2015**



Source: 2014 UNAIDS estimates.

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BEEN SCALED UP AND  
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# Uganda

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## Overview

The population density of Uganda is highest in Kampala and around the other major cities. People living with HIV are spread throughout the country with pockets of high prevalence in a number of regions.

Key populations in Uganda are mainly in Kampala and major towns, fishing communities along the lakes and along major transport corridors.

Sexual transmission continues to be the root of HIV transmission. Women, key populations and urban areas are particularly affected by the epidemic.



## Progress

New HIV infections have declined between 2010 and 2014 in Uganda among both adults and children. Uganda is among the priority countries of the Global Plan towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive that had more than a 60% reduction in new child infections between 2009 and 2014. This has been in part due to sustained expansion of the national programme towards the elimination of new child HIV infections with consistent and high-level commitment and prevention of mother-to-child transmission coverage exceeding 90%.

Similarly AIDS-related deaths have declined, partly because antiretroviral therapy has been rapidly scaled up.

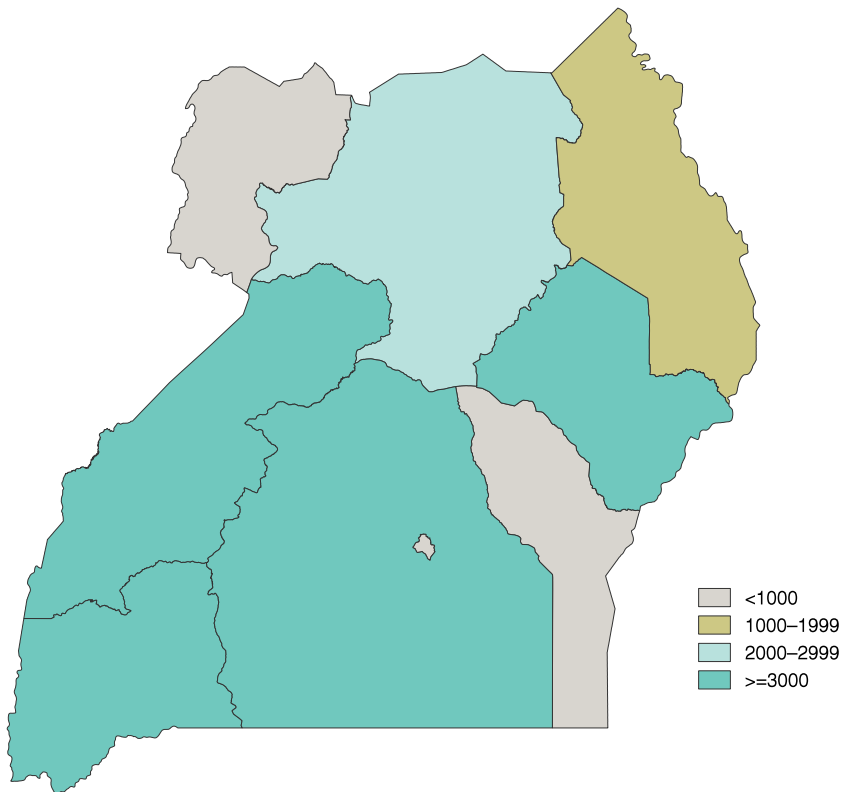
The current national strategic plan and the PEPFAR Country Operational Plan have incorporated the geographical disparity in the HIV epidemic to adjust the services and resources appropriately. This is expected to address the disparities in antiretroviral therapy coverage by sex, age geographical reach and the high levels of stigma and discrimination towards people living with HIV.

## Opportunities

There is good political will and a decentralized health system. The planned engagement of religious leaders, cultural leaders and private sector leaders brings additional needed resources to positively impact the response. There is potential for the country to establish sustainable funding mechanisms to enhance human resources for health, scale up antiretroviral therapy coverage and strengthen supply chain management to cover districts and regions that currently have suboptimal levels of services and high HIV prevalence.

**New infections among women (15–24 years old), 2014**

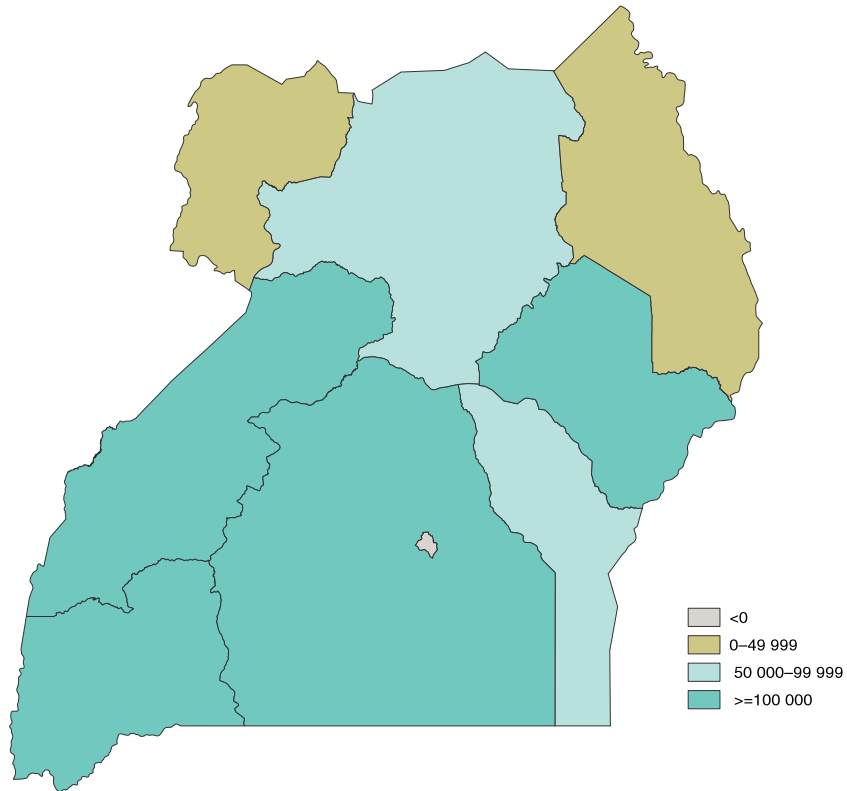
New HIV infections have declined but remain higher among females than males. The disparity between young men and young women has declined over the past decade from a ninefold difference to a threefold difference. Of 10 regions, Central and Western have the highest number of new HIV infections, followed by Mid East and Mid North. The regions with the lowest numbers of young women newly infected with HIV are West Nile, North East, East Central and Kampala. Accordingly, the 2015 PEPFAR Country Operational Plan has given priority to the regions with the highest number of new infections for scale-up.



Source: 2014 preliminary subnational estimates.

**Number of people living with HIV not receiving antiretroviral therapy, 2014**

The national strategic plan has given priority to scaling up antiretroviral therapy and intensifying condom programming. The regions with the largest gap in people receiving antiretroviral therapy are in the southern part of the country.



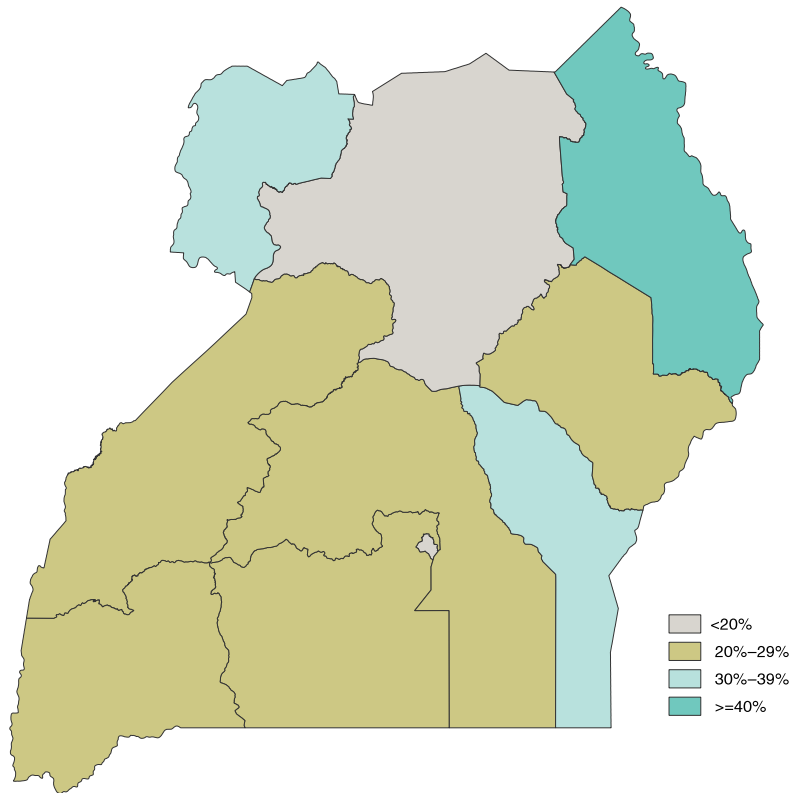
Source: 2014 preliminary subnational estimates.

**Percentage of adults (15–49 years old) who have discriminatory attitudes towards people living with HIV, 2011**

In 3 of 10 regions, 30% or more of the general population reported discriminatory attitudes towards people living with HIV in 2011. The lowest reported rates of discriminatory attitudes were in Kampala and the North Region.

Although more than 90% of people reported they would care for a relative with HIV in their own homes and about 80% thought a female teacher living with HIV should be allowed to continue teaching, about one in five adults believed that people living with HIV should be ashamed of themselves.

Urban women and men were somewhat more likely than rural respondents to express accepting attitudes. Education is positively related to accepting attitudes. The country has planned for a comprehensive stigma reduction campaign in the national strategic plan and a stigma study.



Source: 2011 AIDS indicator survey.

# Ukraine

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## Overview

Ukraine's population is unevenly spread across 27 regions (including Crimea and Donbass), with 50% of the population living in 9% of the regions and 70% of the population concentrated in urban areas.

While injecting drug use was historically the most important mode of transmission, today most of the people newly infected with HIV acquire it through sexual transmission. The HIV epidemic in Ukraine is subdivided into three regional epidemics, with the highest prevalence in nine regions with 40% of the estimated number of people living with HIV. The highest HIV prevalence is in the south-eastern regions of Ukraine, including Odessa, Dnipropetrovsk, Nikolayev, Donetsk and Kherson.

The HIV epidemic has stabilized since 2010, with declining HIV prevalence among young key populations. About 50% of the registered people living with HIV live in three regions, and 30% of the people receiving antiretroviral therapy live in two regions. The HIV epidemic is growing in four regions in the south-eastern part of the country: Odessa, Dnipropetrovsk, Nikolayev and Donetsk.



## Progress

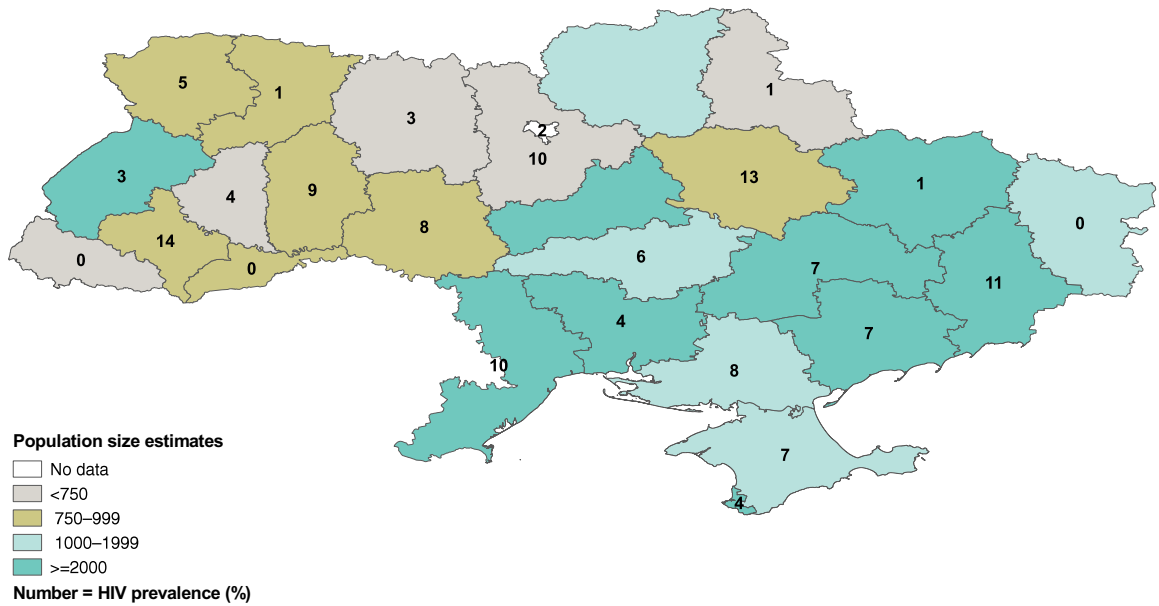
Ukraine is implementing the 6th State AIDS Programme 2014–2018, focusing on prevention services for key populations and antiretroviral therapy. The HIV prevalence is the highest among people who inject drugs, although it has declined from 61% in 2007 to 20% in 2013. The HIV prevalence among female sex workers who inject drugs is four times higher (27%) than among all female sex workers (7%). Antiretroviral therapy was provided to more than 61 000 people living with HIV in 2014. Opioid substitution therapy is provided to more than 8000 people who inject drugs.

## Opportunities

The geographical concentration of key populations and the analysis of the epidemic trends in the most populated regions provide an opportunity for refocusing the distribution of services towards the regions and sites with the greatest number of people living with HIV, allowing for optimization of service delivery and cost-efficiency.

**Female sex workers: population size estimate and HIV prevalence, 2013**

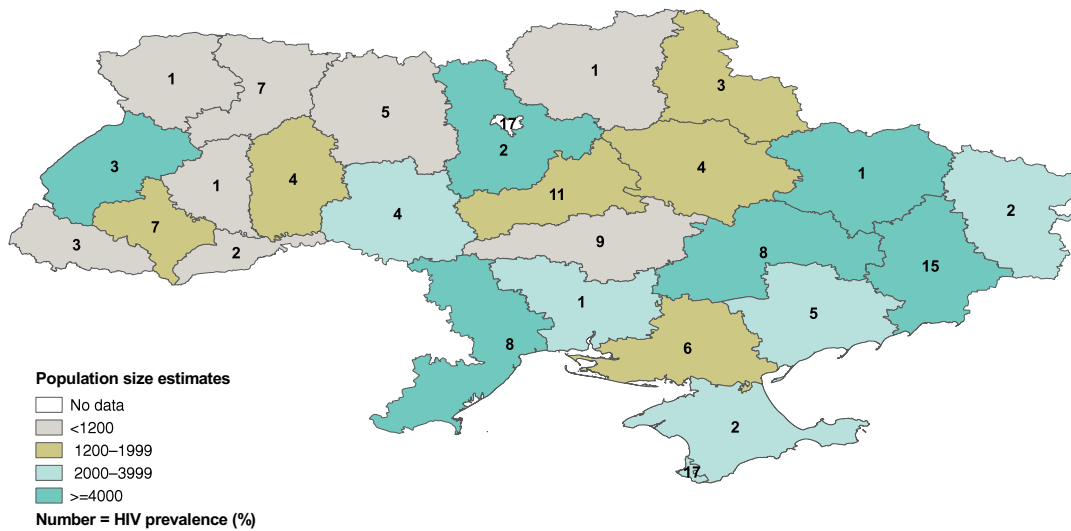
The estimated number of female sex workers in Ukraine is 80 000. High HIV prevalence among female sex workers is found in the southern and eastern parts of the country, while the four regions with the highest prevalence, exceeding 10%, are in the western and central parts of the country. Prevention and treatment services for female sex workers are provided in all regions.



Sources: Balakirieva O et al. Summary of the analytical report Monitoring the behaviour and HIV-infection prevalence among female sex workers as a component of second generation surveillance (according to the results of 2013 bio-behavioural survey). Kyiv: International HIV/AIDS Alliance in Ukraine; 2014 ([http://www.aidsalliance.org.ua/ru/library/our/2014/arep14/zvit%20FSW\\_summary\\_obl\\_ENG.pdf](http://www.aidsalliance.org.ua/ru/library/our/2014/arep14/zvit%20FSW_summary_obl_ENG.pdf)); Analytical report: estimation of the size of populations most-at-risk for HIV infection in Ukraine as of 2012 based on the results of 2011 survey.

**Men who have sex with men: population size estimate and HIV prevalence, 2013**

Ukraine has an estimated 176 000 men who have sex with men. There has been a gradual decrease in the HIV prevalence among men who have sex with men. The regions with higher HIV prevalence among men who have sex with men are the eastern and some southern regions. The highest prevalence of HIV among men who have sex with men has been registered in Donetsk (15%), Kyiv (17%) and Cherkasy (11%).

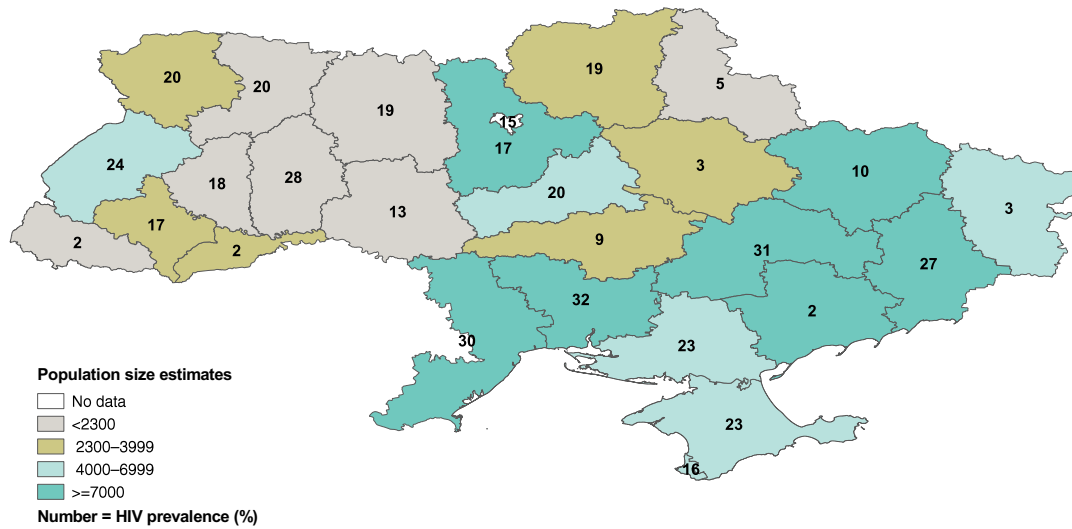


Sources: Bolshov YS et al. Summary of the analytical report Monitoring the behaviour and HIV-infection prevalence among men who have sex with men as a component of HIV second generation surveillance (according to the results of 2013 bio-behavioural survey). Kyiv: International HIV/AIDS Alliance in Ukraine; 2014 ([http://www.aidsalliance.org.ua/ru/library/our/2014/arep14/zvit%20MSM\\_obl\\_eng.pdf](http://www.aidsalliance.org.ua/ru/library/our/2014/arep14/zvit%20MSM_obl_eng.pdf)). Analytical report: estimation of the size of populations most-at-risk for HIV infection in Ukraine as of 2012 based on the results of 2011 survey.

**People who inject drugs: population size estimate and HIV prevalence, 2013**

Ukraine has an estimated 310 000 people who inject drugs, mainly in Kyiv and six regions in the eastern and southern parts of the country. About 50% of the people who inject drugs living with HIV reside in four regions. The HIV prevalence among people who inject drugs is high nearly everywhere. Almost half the regions report an HIV prevalence among people who inject drugs above 20%. Three regions—Mikolayv, Odessa and Dnipropetrovsk—have 21% of the people who inject drugs and report an HIV prevalence among this group above 30%. Harm reduction services are available in all regions of the country.

The services are concentrated in large cities and are provided by nongovernmental organizations.



Sources: Balakirieva O et al. Summary of the analytical report Monitoring the behaviour and HIV-infection prevalence among people who inject drugs as a component of HIV second generation surveillance (according to the results of 2013 bio-behavioural survey). Kyiv: International HIV/AIDS Alliance in Ukraine; 2014 ([http://www.aidsalliance.org.ua/ru/library/our/2014/arep14/zvit%20IDU\\_obl\\_eng.pdf](http://www.aidsalliance.org.ua/ru/library/our/2014/arep14/zvit%20IDU_obl_eng.pdf)); Analytical report: estimation of the size of populations most-at-risk for HIV infection in Ukraine as of 2012 based on the results of 2011 survey.

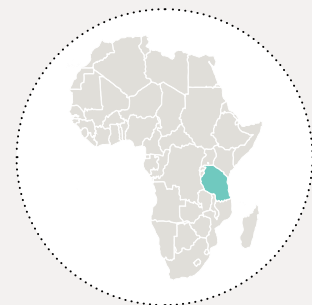
# United Republic of Tanzania

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## Overview

The United Republic of Tanzania has two types of epidemics. The mainland has a generalized epidemic, with significant variation among regions. Half of the country's people living with HIV are concentrated in eight regions South, southern highlands, western highlands and Dar es Salaam. Zanzibar has an epidemic with lower overall prevalence but with high prevalence among key populations. Regions in the North have lower prevalence than the national average.

The HIV prevalence has steadily declined during the past decade. The HIV burden shows marked heterogeneity with regard to age, sex, social economic status and geographical location. The HIV prevalence is higher among women than men and in urban than rural areas.



## Progress

Starting in 2016, all children 0–14 years old living with HIV will receive antiretroviral therapy regardless of CD4 count, and the criteria for eligibility for adults will change from CD4 count <350 cells/mm<sup>3</sup> to <500 cells/mm<sup>3</sup>. Since October 2013, the United Republic of Tanzania has been implementing Option B+ to prevent the mother-to-child transmission of HIV.

Institutional and organizational skills and capacity of civil society organizations, networks of people living with HIV and their members have been developed to enable their active participation in and contribution to a more effectively targeted national response to AIDS.

## Opportunities

With the government focusing largely on providing primary and secondary education free of user charges, there is an opportunity to reach more young people by integrating HIV into the formal education curriculum.

The establishment of the AIDS Trust Fund by the government has created an opportunity to mobilize resources for HIV locally. There are ongoing strategies to strengthen synergy between the public and private sectors, such as by mainstreaming HIV in workplace programmes.

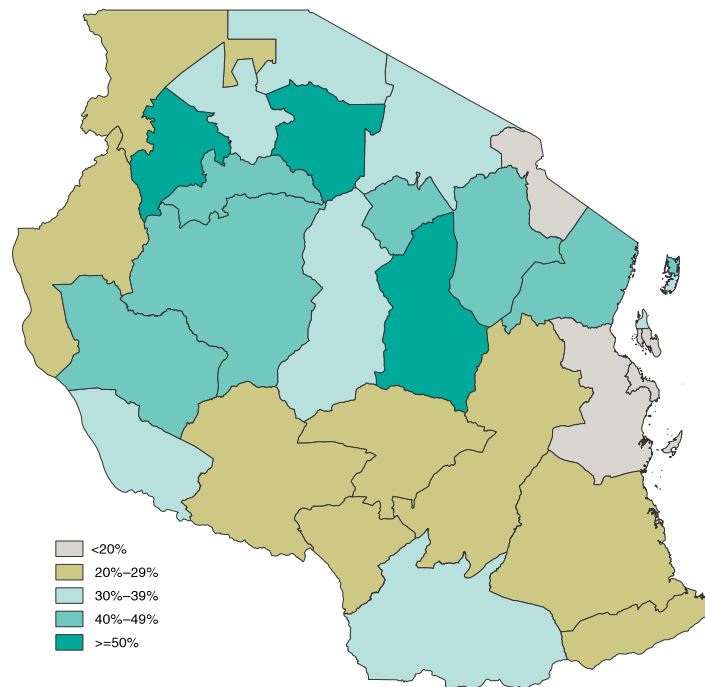
An investment case analysis has provided guidance in setting focused priorities based on impact.

**Percentage of people (15–49 years old) who have discriminatory attitudes towards people living with HIV, 2011–2012**

In 15 of 25 regions in the mainland, more than 30% of people 15–49 years old still have discriminatory attitudes towards people living with HIV. More than 50% of people 15–49 years old in the Dodoma, Geita and Simiyu regions have discriminatory attitudes towards people living with HIV.

Discriminatory attitudes towards people living with HIV could be associated with low comprehensive knowledge of HIV. The level of comprehensive knowledge about HIV is low in the mainland (less than 50%).

In the three regions where more than 50% of adults have discriminatory attitudes towards people living with HIV, the level of comprehensive knowledge is below the national average.



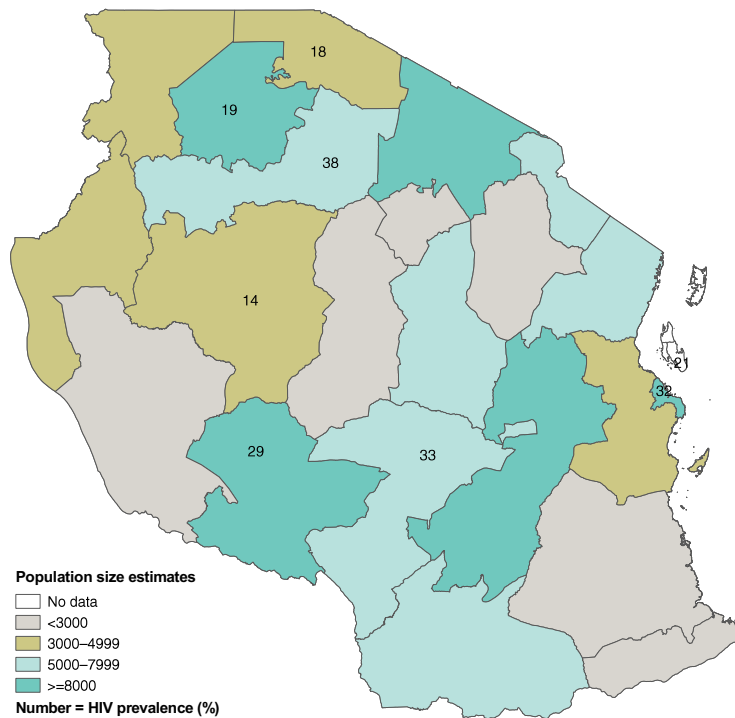
Source: 2011–2012 AIDS Indicator Survey.

**Female sex workers: population size estimate and HIV prevalence**

Female sex workers are present throughout the United Republic of Tanzania.

A study in seven regions (Dar-es-Salaam, Iringa, Mara, Mbeya, Mwanza, Shinyanga and Tabora) indicated that the HIV prevalence among female sex workers ranged from 38% in Shinyanga to 14% in Tabora. Stakeholders in collaboration with the Ministry of Health and Social Welfare are implementing intensive testing, treatment and prevention programmes among female sex workers in 14 of 25 regions in the mainland.

In Zanzibar, an Integrated Biological and Behavioural Survey conducted in 2011–2012 estimated the HIV prevalence to be 19.3% among female sex workers, an increase from 10.8% in 2007. An outreach programme by the Ministry of Health and other stakeholders is providing testing, treatment and prevention services to this population. Female sex workers living with HIV are provided with antiretroviral therapy regardless of CD4 count.



Sources: Global AIDS Response Progress Reporting, 2015; Khalid F et al. Doubling of HIV prevalence among female sex workers (FSW) in Zanzibar assessed through respondent-driven sampling (RDS) surveys, 2007 to 2011 (<http://globalhealthsciences.ucsf.edu/sites/default/files/content/pphg/posters/FSW-CROI-Poster-27Feb2013v3.pdf>); Consensus estimates on key population size and HIV prevalence in Tanzania, 2014. Dar es Salaam: National AIDS Control Programme, United Republic of Tanzania; 2014 ([http://www.healthpolicyproject.com/pubs/391\\_FORMATTEDTanzaniaKPconsensusmtgreport.pdf](http://www.healthpolicyproject.com/pubs/391_FORMATTEDTanzaniaKPconsensusmtgreport.pdf)).

**STAKEHOLDERS IN COLLABORATION WITH  
THE MINISTRY OF HEALTH AND SOCIAL  
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TESTING, TREATMENT AND PREVENTION  
PROGRAMMES AMONG FEMALE SEX  
WORKERS IN 14 OF 25 REGIONS ON THE  
MAINLAND OF THE UNITED  
REPUBLIC OF TANZANIA.**

# Viet Nam

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## Overview

The HIV epidemic in Viet Nam is concentrated primarily among people who inject drugs, men who have sex with men and female sex workers. These populations are mostly concentrated in mountainous northern provinces and large urban centres. In 2014, Viet Nam had an estimated 251 000 people living with HIV and 14 000 people newly infected with HIV. Most of the people newly infected continue to be people who inject drugs, but the number of low-risk women newly infected is increasing, primarily among the partners of men who inject drugs, visit sex workers or have sex with other men.



## Progress

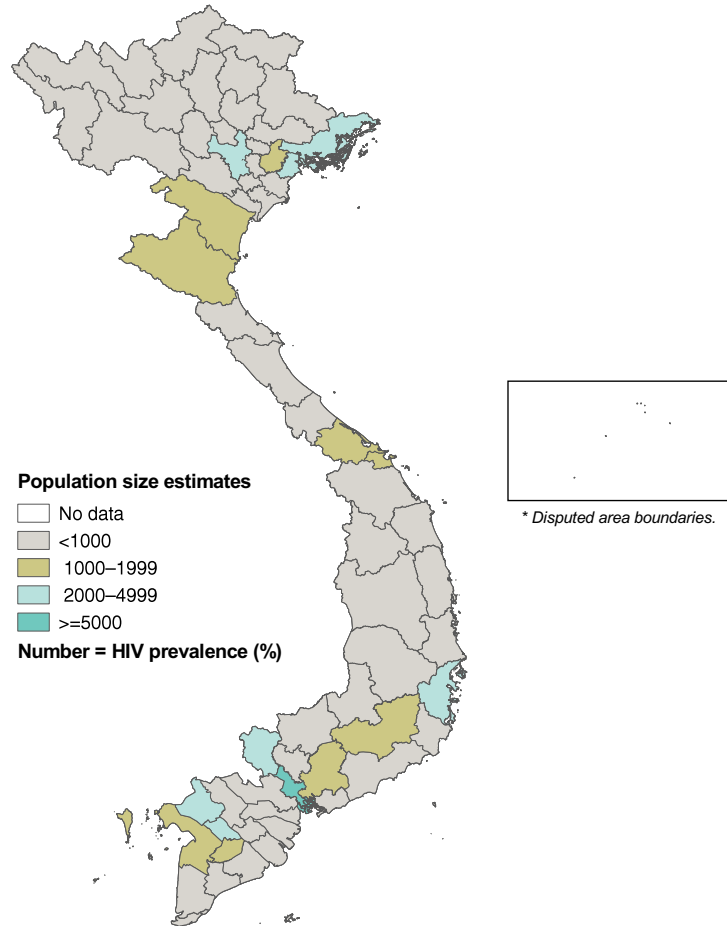
Under strong and consistent leadership, Viet Nam has achieved important successes against the epidemic. However, HIV remains a formidable challenge for Viet Nam. Although the number of people receiving antiretroviral therapy has increased dramatically in recent years, the level of coverage is not sufficient to control the epidemic. Stigma and discrimination are significant barriers to the uptake of HIV services. Rapidly declining donor support is a challenge for Viet Nam's progress against HIV, with about 75% of the funding for the HIV response coming from external sources.

## Opportunities

Fast-Tracking the response in Viet Nam will entail urgent action to achieve the country's commitment to the 90–90–90 treatment target, with a particular and intensified focus on innovative and effective service delivery in the response among key populations and in geographical settings where the need is greatest, elimination of stigma and discrimination and efficient use of domestic funding.

**Sex workers: population size estimate and HIV prevalence, 2013–2014**

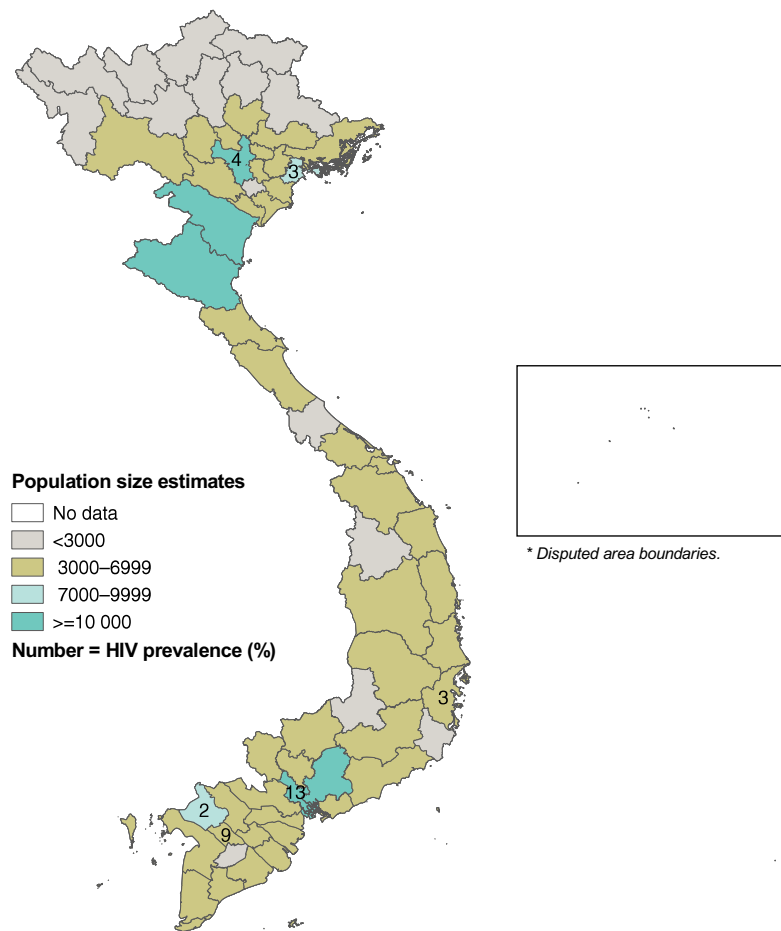
The HIV prevalence among sex workers in Viet Nam varies by province and is highest in Ha Noi, Hai Phong, Can Tho and Ho Chi Minh City. Evidence also indicates that street-based female sex workers have a higher HIV prevalence than venue-based female sex workers, and an estimated 3–8% of female sex workers also inject drugs. Peer outreach workers provide prevention services to female sex workers.



Sources: Viet Nam AIDS response progress report. 2014; HIV sentinel surveillance with a behavioural component (HSS+) and integrated biological and behavioural surveys (IBBS), 2013; Review of data on female sex workers for the Asian Epidemic Model (AEM) (annex table); Global AIDS Response Progress Reporting 2015; 2013 HIV estimates.

**Men who have sex with men: population size estimate and HIV prevalence, 2013–2014**

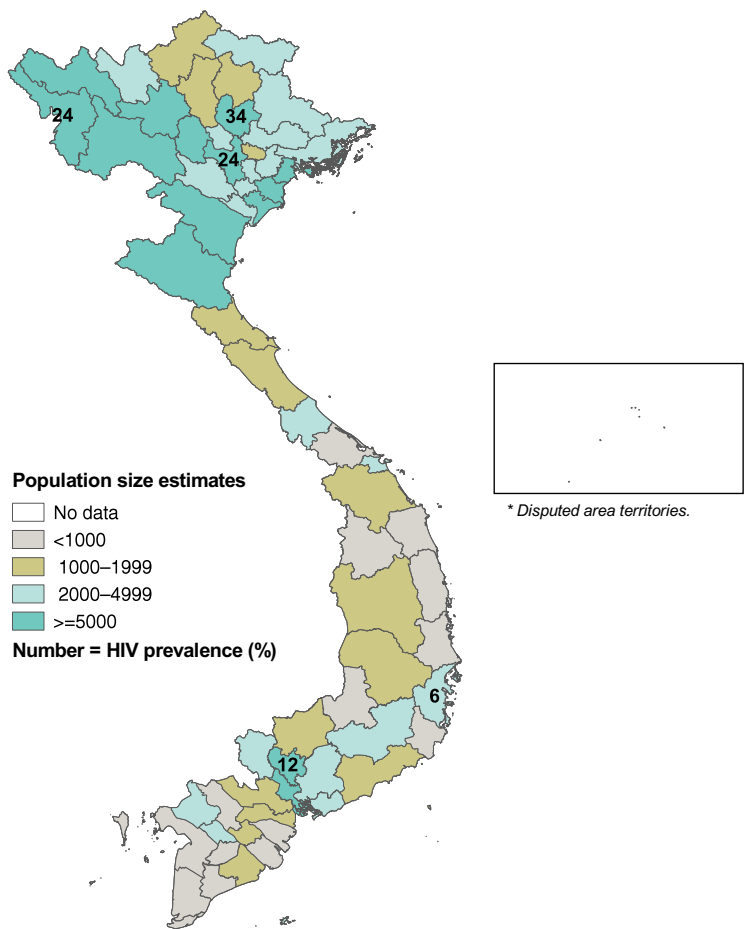
The estimates of the number of men who have sex with men suggest that the cities have some of the larger populations. Although the HIV prevalence varies among areas, it is highest in Hanoi and relatively high in Ho Chi Minh City. Behaviour change communication and condom and lubricant distribution focusing on men who have sex with men have been rolled out in recent years, and more than two thirds of the men who have sex with men surveyed report using a condom the last time they had anal sex with a male partner.



Sources: Viet Nam AIDS response progress report, 2014; HIV sentinel surveillance with a behavioural component (HSS+) and Integrated Biological and Behavioural Surveys (IBBS), 2013; Global AIDS Response Progress Reporting, 2015; 2013 HIV estimates.

**People who inject drugs: population size estimate and HIV prevalence, 2010–2013**

Many people who inject drugs live in the mountainous north-western provinces near the China and Lao borders or in large urban centres. Some of the highest HIV prevalence levels are recorded in these areas. In remote and mountainous areas, socioeconomic development is not as advanced as in urban areas, understanding of the risks of acquiring HIV risks is limited, transport is difficult and access to HIV services is lacking. Recent expansion efforts in community-based services in the North are providing HIV testing to many people living in the mountainous areas.



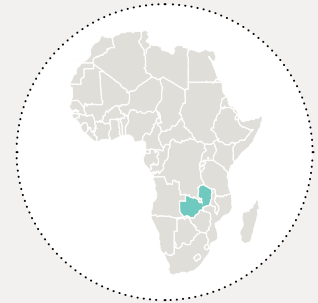
Sources: Viet Nam AIDS response progress report, 2014; HIV sentinel surveillance with a behavioural component (HSS+) and Integrated Biological and Behavioural Surveys (IBBS), 2013; Review of data on people who inject drugs for the Asian epidemic model (AEM) (annex table); Global AIDS Response Progress Reporting, 2015; 2013 HIV estimates.

# Zambia

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## Overview

The population density in Zambia is highest in the predominantly urban regions of Copperbelt in the central-northern part of the country and in Lusaka, in the central-southern part of the country. The HIV prevalence is also highest in these regions. These regions have populations of migrants who temporarily move to other areas for work opportunities.

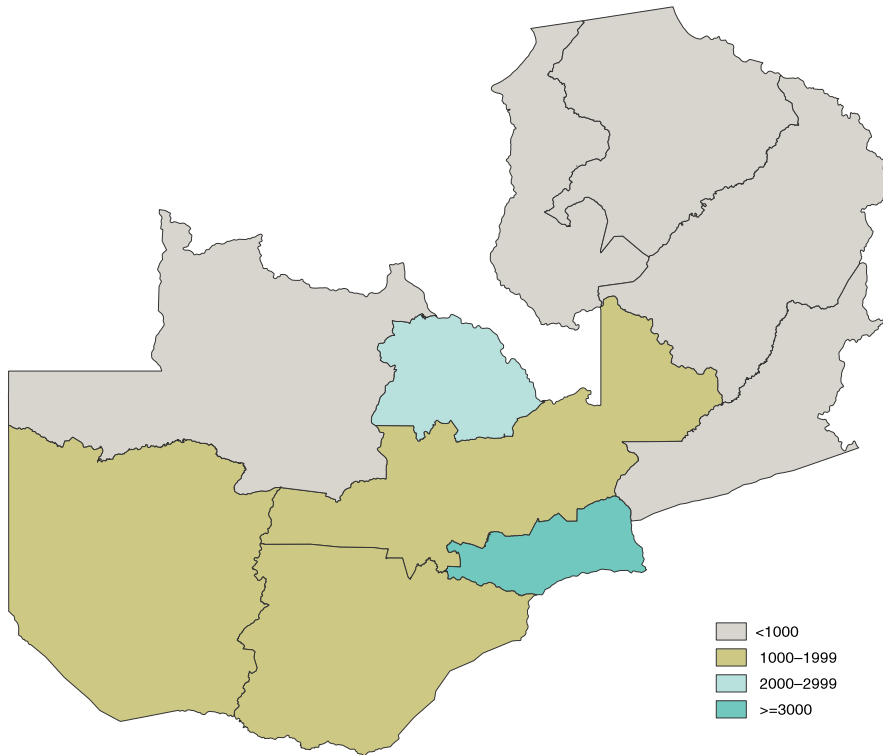


## Progress

Zambia's antiretroviral therapy programme continues to show impressive performance. In 2014, 671 066 adults and children were receiving antiretroviral therapy. Of these, more than 100 000 newly initiated antiretroviral therapy during the year. Access to treatment within and between provinces varies considerably. Services for preventing mother-to-child transmission have been integrated into maternal and child health programming while also shifting to providing lifelong treatment to all pregnant women living with HIV. Zambia has endorsed the implementation of task shifting, which allows nurses to be certified to prescribe antiretroviral medicines.

**New infections among women (15–24 years old), 2014**

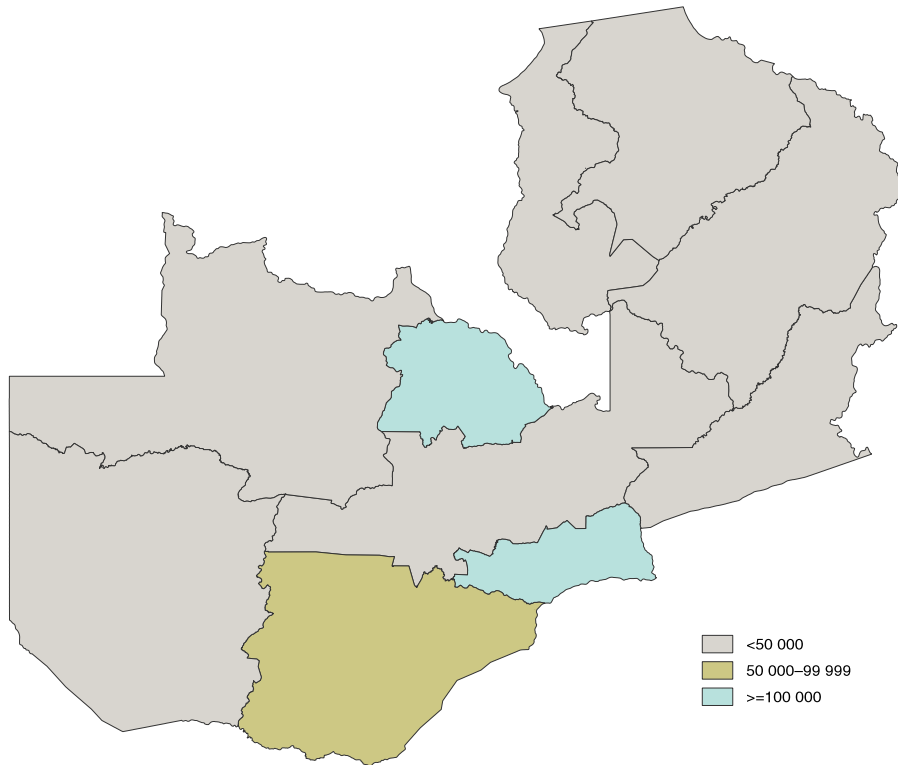
Most of the women 15–24 years old newly infected with HIV live in Lusaka and Copperbelt.



Source: 2014 Zambia preliminary subnational estimates.

**Number of people living with HIV not receiving antiretroviral therapy, mid-2015**

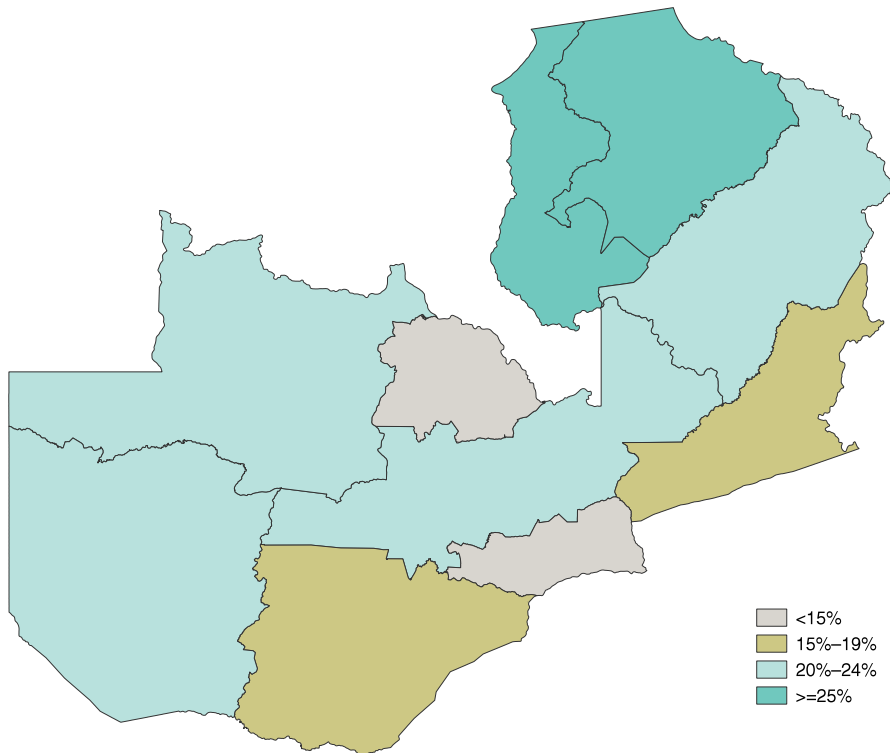
The need for antiretroviral therapy is highest in Lusaka and Copperbelt provinces, which are home to large populations.



Sources: 2014 Zambia preliminary subnational estimates and mid-2015 data on antiretroviral therapy submitted through the Global AIDS Response Progress Reporting.

**Percentage of people (15–49 years old) who have discriminatory attitudes towards people living with HIV, 2013–2014**

The provinces with the lowest exposure to HIV have the highest discriminatory attitudes. The Northern and Luapula provinces have the highest levels of discriminatory attitudes, and Lusaka and Copperbelt provinces have the lowest levels of discriminatory attitudes.



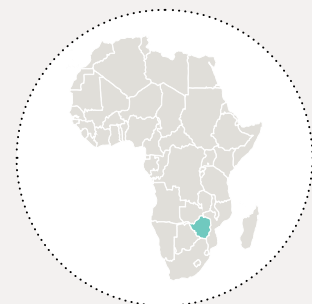
Source: 2013–2014 Demographic and Health Survey.

# Zimbabwe

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## Overview

The population of Zimbabwe is spread unevenly among its rural provinces, with the highest density in the eastern provinces and the lowest in the southern region. Most new HIV infections are through heterosexual sexual transmission. The HIV prevalence is higher in urban areas than in rural areas. The HIV prevalence is 1.5 times higher among women 15–24 years old than among their male counterparts.



## Progress

The number of new HIV infections is declining. More people living with HIV know their status and are receiving HIV treatment, and AIDS-related deaths have decreased. The number of men who opt for voluntary medical male circumcision in the country has increased; tuberculosis-related deaths among people living with HIV have also declined.

## Opportunities

The need for services is clustered near the capital city and other major cities, enabling cost-efficiency in reaching people living with HIV with treatment services and key populations with prevention services, as well as focusing on the regions where most new infections are occurring.

Within the provinces, individual districts have been identified with high HIV prevalence and need to be given priority.

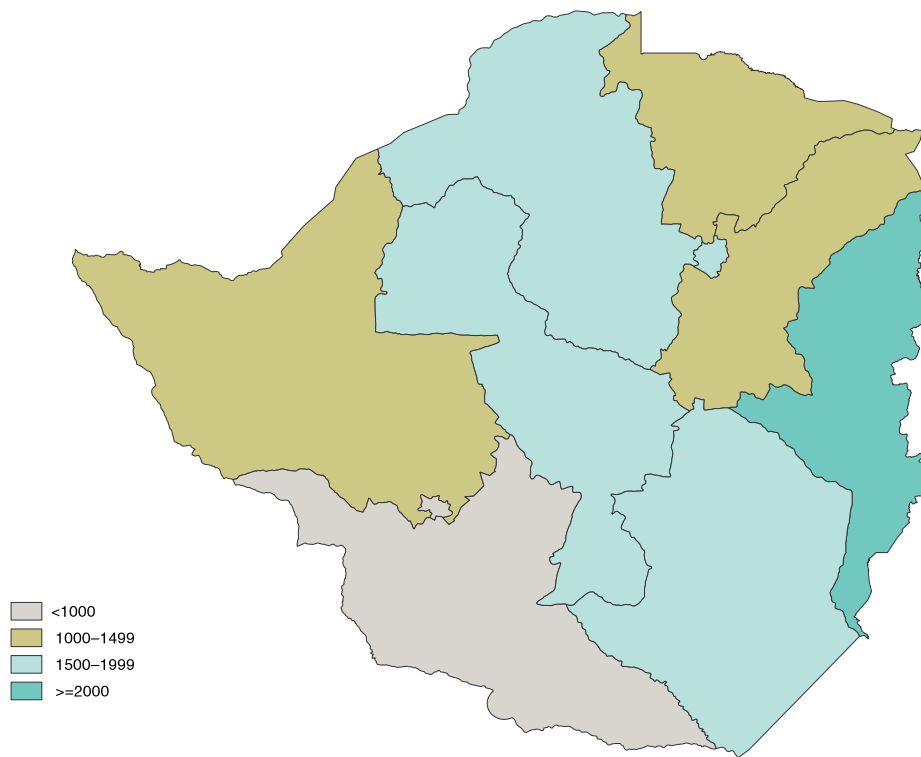
There has been a decline in sexually transmitted infections recorded at public health facilities, but there are recent reports of sexually transmitted infections increasing among certain population groups, including young people in Harare and mine workers in Mhondoro-Ngezi district. This needs to be considered by HIV prevention efforts. The limited data availability for key populations, including on HIV prevalence and size estimates, needs to be addressed for effective planning and service delivery.

**New infections among women (15–24 years old), 2013**

Manicaland in eastern Zimbabwe, bordering Mozambique, had the highest number of new HIV infections among young women in 2013.

The country has implemented plans to improve matching of prevention responses to where most new infections occur. A mapping exercise and analysis have informed planning.

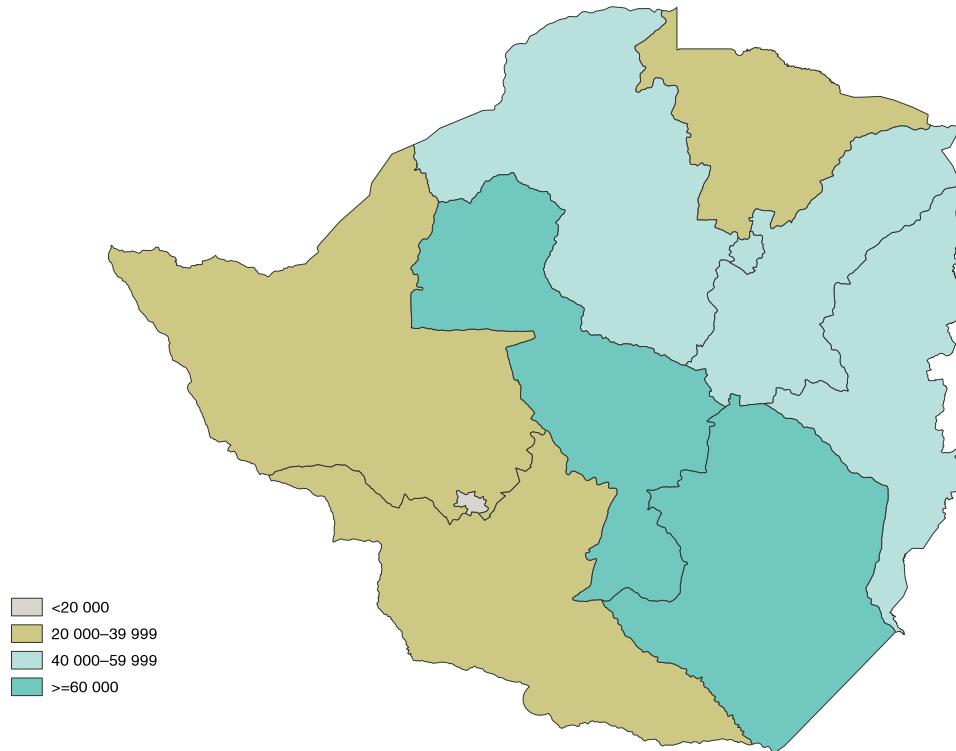
Many initiatives addressing young people are currently being implemented through community-, health facility- and school-based approaches.



Source: 2013 Zimbabwe subnational HIV estimates.

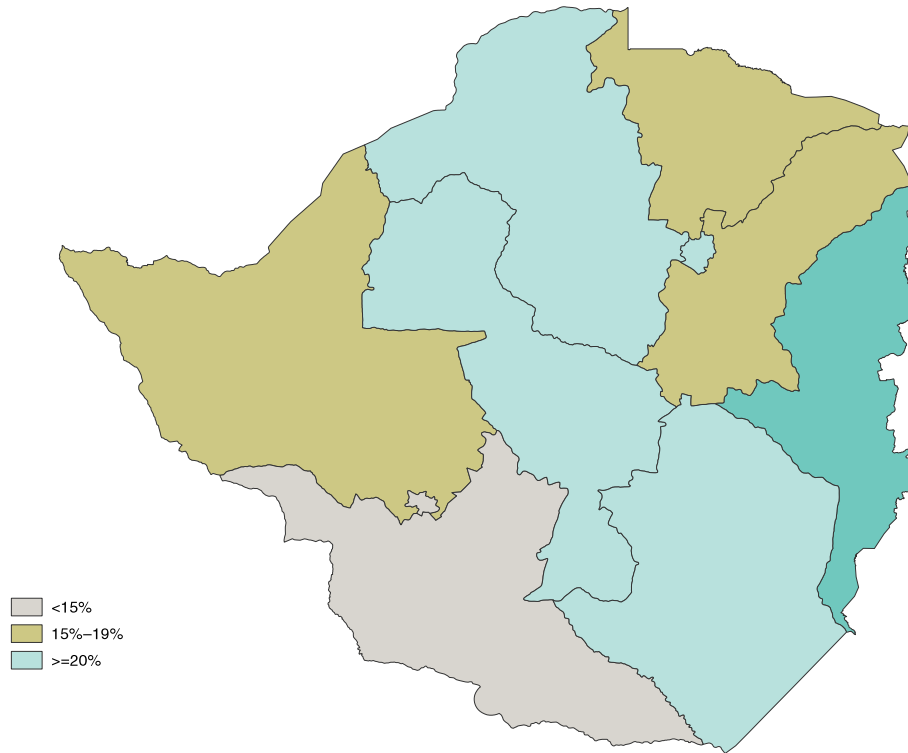
**Number of adults (15–49 years old) living with HIV who have never been tested for HIV, 2010–2011**

Data suggest that most of the people living with HIV who have never been tested for HIV resides in the Midlands, Masvingo, Mashonaland West, Mashonaland East, Manicaland and Harare provinces. Addressing gaps in the provision of HIV testing services in these provinces would be important to increase the number of people identified who are in need of treatment.



Sources: 2010–2011 Demographic and Health Survey and 2013 Zimbabwe preliminary subnational HIV estimates.

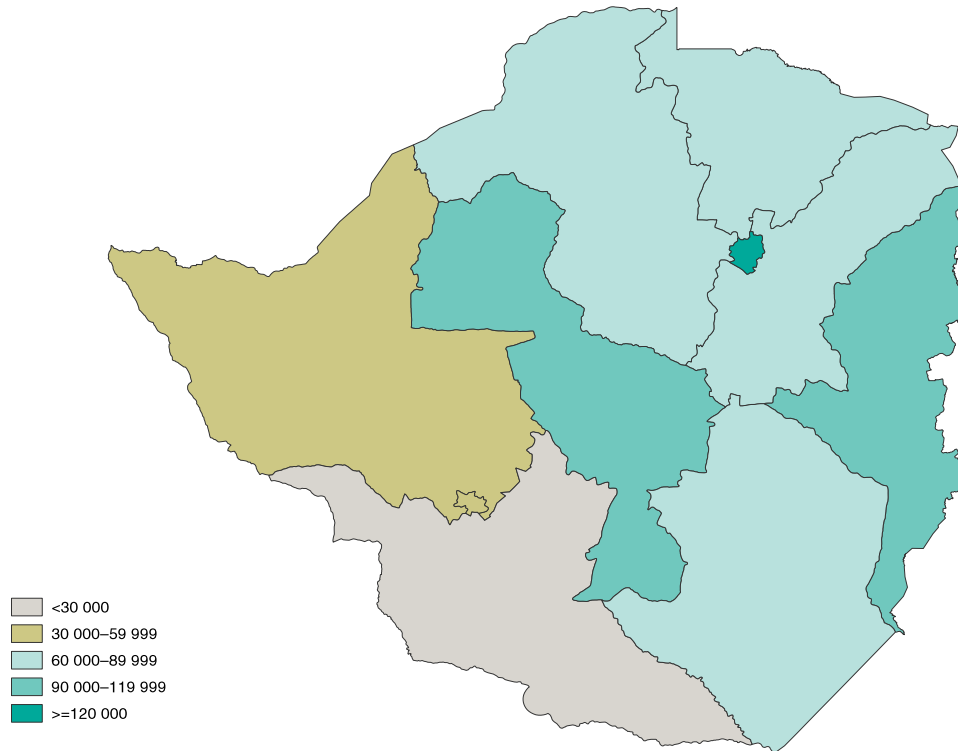
**Percentage of people 15–49 years old who have discriminatory attitudes towards people living with HIV, 2013**



Sources: 2010–2011 Demographic and Health Survey and 2013 subnational HIV estimates.

**Number of people living with HIV not receiving antiretroviral therapy, 2014**

Among the 290 000 people living with HIV in Harare, over 120 000 are not receiving antiretroviral therapy. Efforts to reach people through testing outreach and other community-based services are needed to close this gap.



Sources: 2010–2011 Demographic and Health Survey and 2013 subnational HIV estimates.

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## Conclusion

1. New formulation of HIV treatment to save more children's lives. UNICEF and UNAIDS joint press release. 5 June 2015. In: UNICEF: press centre ([http://www.unicef.org/media/media\\_82194.html](http://www.unicef.org/media/media_82194.html), accessed 10 November 2015).

The first part of the document discusses the importance of maintaining accurate records in a business setting. It highlights how proper record-keeping can help in decision-making, legal compliance, and financial management. The text emphasizes that records should be organized, up-to-date, and easily accessible.

Next, the document addresses the challenges of data management in the digital age. It notes that while digital storage offers convenience, it also introduces risks such as data loss, security breaches, and information overload. Solutions like cloud storage, encryption, and regular backups are suggested to mitigate these risks.

The third section focuses on the role of technology in streamlining business processes. It describes how automation and software solutions can reduce manual errors, save time, and improve overall efficiency. Examples of such technologies include accounting software, CRM systems, and project management tools.

Finally, the document concludes by stressing the importance of employee training and awareness. It suggests that investing in education and skill development can lead to a more productive and adaptable workforce. Regular updates on new technologies and best practices are recommended to keep the organization competitive in a rapidly changing market.







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