GETTING TO ZERO: HOW WILL WE FAST-TRACK THE AIDS RESPONSE?

Discussion paper for consultations on UNAIDS Strategy 2016-2021

#UNAIDSstrategy2021

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Inspired by unprecedented progress over the last several years, the international AIDS community, including the UNAIDS Programme Coordinating Board (PCB), has embraced the ambition of ending the AIDS epidemic by 2030. To get there, the PCB has asked for the development of an updated UNAIDS Strategy 2016-2021 to guide progress towards several ambitious “Fast-Track” targets.

Fast-Tracking the response will rely on front-loading investments and accelerating rights-based action in the coming years – while accounting for a rapidly shifting geopolitical context and evolving HIV epidemic. It will also mean fundamentally changing the way the response supports those populations that continue to be left behind – as explored in depth in the UNAIDS Gap Report.

Quickening the pace over the next six years is pivotal to global prospects for bringing the AIDS epidemic to an end. Continuing at the current pace will mean continuing to leave people behind, exacerbating inequalities, unsustainably expanding costs and compromising social justice (Fig.2). An ambitious global strategy is required to take us forward – one that mobilizes political commitment, focuses resources and accelerates progress.

Thus, as the end date of the UNAIDS 2011-2015 Strategy nears, and we endeavor towards a Strategy for 2016-2021, we are presented with a critical opportunity and obligation: Through global, regional, thematic and virtual consultations we hope to arrive at an understanding of where we have succeeded and where challenges remain – and collectively define what we must achieve by 2021 and what must be done differently to get there.
Fig. 1 Number of people living with HIV, new HIV infections and AIDS-related deaths, 1990-2013

Fig. 2 Impact of reaching the Fast-Track targets by 2020: People living with HIV (PLWHA) and total number of new HIV infections (in bold)
The aim of this consultation is to explore the following questions:

1. How will developments – globally and in the region – impact the epidemic and response in the region, in countries and at the sub-national level over the next six years?

2. What achievements of the regional response should be expanded and built upon? Where are the main challenges and gaps? Who is being left behind and why?

3. In order to reach the Fast-Track targets, what should be the region's strategic priorities in the response?

4. What will need to change in support of those priorities? What are the “game-changers” – in terms of policy and law reform, funding, resource allocation, partnerships, service delivery, empowering civil society, science and innovation, and links with other health and development efforts?

5. What are the most critical ways in which the UNAIDS Joint Programme can support efforts in the region to end AIDS as a public health threat by 2030?
Introduction

This paper seeks to inform and provoke discussion at a series of regional consultations convened to consider the future of the global AIDS response and to inform the development of UNAIDS Strategy for the period 2016-2021. Consultations will engage all stakeholders including people living with HIV, governments, NGOs including networks of key populations and young people, academia, private sector and international and regional organisations.

The paper explores a number of the leading geopolitical shifts that characterise the world today, and which carry potentially far-reaching implications for the AIDS epidemic and response. It presents the rationale and imperative for “Fast-Tracking” the response in the coming five years, while exploring and inviting discussion on the remaining gaps – at global and regional levels.

Ultimately, through a series of questions, the paper – and the consultation – aims to provoke a discussion on regional priorities, and determining what needs to be done differently in the response to achieve our ambitious aims for 2021.

Several annexes provide an overview of the UNAIDS 2011-2015 Strategy (Annex 1), a snap shot of progress in the global epidemic and response (Annex 2), a selection of the contributions of the Joint Programme to progress (Annex 3), and a set of draft targets for 2020 to monitor progress towards zero discrimination (Annex 4).

Request of the UNAIDS Board

The UNAIDS Board has requested its Executive Director to undertake a multi-stakeholder consultative process to update and extend the existing Strategy through the Fast-track period, in the context of reaffirming and building upon:

- the UNAIDS Vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths, and

- the 10 goals and three strategic directions of the UNAIDS 2011-2015 Strategy: 1) Revolutionize HIV prevention; 2) Catalyze the next phase of treatment, care and support; and 3) Advance human rights and gender equality for the HIV response (See Annexes 1 and 2 for further detail).

Consultation outcomes

UNAIDS Regional offices will prepare a concise consultation report that will serve to inform the Global Consultation on the UNAIDS Strategy, scheduled to be held in Geneva on 15-16 April. The Global Consultation will review reports and recommendations submitted by all regional, thematic and virtual consultations. To arrive at a final consultation report, UNAIDS Regional Offices may chose to host some form of virtual consultation with participants given likely constraints to the time and scope of the in-person consultations.

We sincerely appreciate your ongoing support and commitment to the Strategy development process.
Negotiating a post-2015 world: What does the shifting global context mean for AIDS?

The dynamics of the AIDS epidemic and response interact in a profound and complex way with the rapidly changing context.

A more unequal world

Economic and social inequality is on the rise. Today, 75% of the population in developing countries live in more unequal societies than in 1990.\(^1\) Financial inequalities are compounded by unequal access to power, education and healthcare: children born in the poorest households are the least like to finish primary school; and women in rural areas are three times more likely to die in childbirth than their urban counterparts. Socio-economic inequality is closely linked to HIV prevalence – across regions.\(^2\)

The rise of the MICs: A new dynamic in the geography of poverty and global health

Today, three out of four poor people live in middle-income countries (MICs)\(^3\). Even with predicted economic progress in middle-income countries, in 2020, these countries are still likely to be home to half of all people living on less than $2/day and will continue to carry the bulk of the global burden of disease – including 70% of people living with HIV. Today, middle-income countries (MICs) are facing a crisis of containing costs for treating people living with HIV.\(^4\) International aid and assistance, however, still focuses on low-income countries. The recent increase in domestic resources available for the AIDS response will need to be accelerated and sustained. The shift in the geography of poverty has major implications for financing, delivering and governing the AIDS response, and broader global health.


\(^4\) Global Network of People Living with HIV (GNP+). Access challenges for HIV treatment among people living with HIV and key populations in middle-income countries. October, 2013.
The economies and influence of many MICs are growing as they become increasingly integrated into both global and regional markets – stimulating the proliferation of regional and sub-regional mechanisms of cooperation. Such regional blocs between countries offer an opportunity to strategize, mobilize political commitment, strengthen knowledge sharing among networks and key stakeholders, and foster a platform to address cross-border, collective challenges that intersect with the HIV epidemic, such as migration and forced displacement.

**MICs, LMICs and fragile states: A more nuanced role for development cooperation**

A major debate has been unfolding on the future of development cooperation and the role of aid, particularly in middle-income countries. The notion of aid, where poor countries have development challenges, wealthy countries have solutions and resources, is increasingly out-dated. Emerging economies are demanding and instilling a new approach to cooperation. The BRICS countries, for instance, are bringing a new value system that emphasizes “south-south” cooperation, sovereignty and economic development.

Several traditional development partners are reducing and/or discontinuing support to middle-income countries – despite significant burdens of disease, poverty and increasing inequality, and inadequate social protection. By 2030, only 14 of the current 82 countries currently eligible for concessional programmes of multilateral banks are projected to still be eligible, if current rules continue to apply. Meanwhile, many lower MICs have much more in common with low-income countries (LICs) than with upper MICs in their development realities, while there are also reversals where countries may fall back to LIC status. In this context, challenges arise regarding how to ensure sustainability of AIDS gains, how to ensure that AIDS remains a domestic political priority, and how to accelerate scale-up to end the epidemic. In these countries, many argue that traditional aid must transition from playing a supplementary role to a catalytic role—including catalyzing more private investments.

The story in low-income and fragile states is different to that of middle-income countries. While projections vary, some assessments of the dynamics of growth and demographics suggest that, by 2025, as middle-income countries lift their populations out of poverty, at least half of all absolute poverty will once again be found in low-income and/or fragile countries primarily in Africa. In this context, a major challenge is how best to ensure access to quality services for people living in such settings who face multiple vulnerabilities: high susceptibility to recurrent humanitarian emergencies, war, violence (including sexual violence), disease, food insecurity, environmental degradation, and corrupt/weak institutions – exacerbated by lack of education, health care, social protection mechanisms and infrastructure.

**Urbanization compounds inequality at the sub-national level**

By 2020, 56% of the world population will live in urban settings, where HIV prevalence is higher and poverty is growing faster than in rural areas. Nearly all (about 90%) of the world’s urban population growth between now and 2030 is expected to be in developing countries, mostly in Africa and Asia (Fig. 3). Furthermore, one billion people are living in urban slums, which are typically overcrowded,

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6 The World Bank’s latest list of “fragile situations” includes 33 countries and territories, identified by weak Country Policy and Institutional Assessment ratings, or the presence of a UN and/or peace-keeping or political/peace-building mission during the past three years. Countries are characterized by deteriorating governance, states in prolonged political crisis, post-conflict transition countries or those undergoing gradual but still fragile reform processes.
polluted and dangerous, and lack basic services such as clean water and sanitation. In Nairobi, for example, the prevalence of HIV in the slum population was reported as 12% compared to 5% in the non-slum population.7

Yet while cities have more “resources” that can be leveraged to reach a majority of city residents with services, urban responses to the epidemic have been sparse, poorly coordinated and insufficiently evidence-based. National planning often does not take into account the complexities of urban settings in terms of service delivery and varying degrees of vulnerability.

Fig 3. Urban and rural population trends in ‘developing’ countries, 1950–2050

The rise of social media as a tool for sharing information, organising and accountability

Social media and mobile technologies are increasingly providing a revolutionary array of tools to address limitations in current service delivery systems, ensure financial transparency and reform advocacy, outreach, and mobilization. They offer the ability to connect people from remote parts of the world to share experiences and information, a potentially cheap and efficient way to monitor real-time programmatic gaps and progress, and to equip citizens with data, enhance their participation in the public sphere and extend their agency over development-related decision-making. In the AIDS response, new information and communication technologies can support prevention strategies, improve treatment adherence, and strengthen local response monitoring systems, including on human rights violations.

The evolving HIV epidemic: Importance of location and population

The distribution of new infections within populations has also been changing steadily in many countries. While declining among the general population in many parts of the world, HIV epidemics among key populations are on the rise in many places. At the same time, increasingly polarized and conservative views on matters of sexuality and sexual and reproductive health and rights (SRHR) are working to further marginalize these already vulnerable populations. The criminalization of sex work, drug use and same-sex relationships among consenting adults in a large number of countries continues to hinder reaching people at higher risk of HIV infection with the services that have been shown to prevent and treat HIV.

Across countries, young people remain at the centre of the HIV epidemic. Structural, social and behavioural dynamics make young people – and particularly young women and girls – vulnerable to HIV. Half of all people in Africa today are under 18 where young people account for 40% of new HIV infections, and young women are more than twice as likely to be living with HIV than young men. In contrast, the median age is 30 in Asia (see Fig.4). A growing population of young people in high HIV burden countries may result in yet further expansion of the epidemic unless we reach this cohort with evidence-informed, rights-based and tailored services.

At the same time, with growing access to treatment, many people living with HIV are ageing. Long-term antiretroviral therapy has been linked to increased risk of non-communicable (NCD) diseases – demanding stronger linkages between HIV and NCD service delivery.

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8 UNAIDS Strategy 2011-2015 defines key populations, or key populations at higher risk, as groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.
Increasingly, the old concept of concentrated, mixed and generalized epidemics is making way for a new approach of viewing and responding to the epidemic—the AIDS epidemic is about location and population (See Map, Page 12). Although regional and national data help to provide a snapshot of the epidemic, they hide the subnational and local diversities of the AIDS epidemic. In Kenya, HIV prevalence varies significantly between provinces—from 2.1 in North Eastern to 4.9% in Nairobi and 15.1% in Nyanza. Within local epidemics, select populations are disproportionately affected. In the city of Jayawijaya in Indonesia, female sex workers had an HIV prevalence of 25% - this compared to a national HIV prevalence among sex workers of 9%, and prevalence among all women below 1%. Countries are increasingly focusing on local epidemics for higher-impact and more cost-effective programming.

**AIDS in the context of the expanding post-2015 global health agenda**

While the post-2015 development agenda is not yet adopted, many of the elements appear to enjoy consensus already—including a health goal that extends beyond AIDS, TB and malaria to include universal health coverage (UHC), NCDs, road traffic accidents and pollution-related ill-health, among other targets. The expanded health agenda provides opportunities for better integration of HIV services with other health services. The post-2015 agenda as a whole presents opportunities to promote synergies across development sectors, for example on fulfillment of human rights, inclusive social protection, education, inclusive and resilient cities, and decent work for all.

UHC provides an opportunity to increase domestic funding for HIV services, but could also represent a setback to the AIDS response, as low-income countries may not generate budgets large enough to cover all UHC services—including HIV treatment. Furthermore, an expanded health agenda offers significant opportunity to pursue multisectoral and joined-up efforts among different health responses. Weakened visibility of the AIDS response however may lead to losing many of the more unique aspects of the AIDS response—such as the participation and empowerment of affected communities, rights-based multisectoral responses, or a focus on punitive laws, lack of human rights protection and stigma and discrimination.

Thus while international assistance is stagnating (and not available to certain countries), the ambition of the global health community to augment the unfinished MDG agenda with new priorities will significantly increase the resource needs envelope.

While innovative and effective in mobilizing resources, the global instruments used to support countries to co-finance their AIDS responses are facing challenges. Under pressure to demonstrate results for public funds, PEPFAR’s latest 3.0 Strategy is streamlining the investment portfolio to be more directly in line with the HIV epidemic burden, and high-impact opportunities.

The Global Fund model has been updated to ensure more flexible timing, better alignment to national strategies, greater predictability of funding, and more active engagement of in-country partners. Yet the Global Fund’s ability to reach many of those most in need in middle-income countries is hindered by restrictions on country eligibility. Some constituencies have called for the Global Fund to further leverage grants for broader progress on health—recognizing that people affected by HIV, TB and

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malaria also face a range of other health risks. While grant tracks are available for countries to apply for funding for health system strengthening, the Board has explicitly directed the Global Fund to maintain its focus on AIDS, TB and Malaria as it develops its Strategy for 2017-2021.

Thus the international AIDS architecture continues to struggle with the challenge of being accountable for delivering results in the AIDS response – while increasingly cognizant that progress is contingent on the broader health, education, legal and other systems and addressing the determinants of vulnerability.

**Risks to commodity security**

As the global health agenda expands, with the concomitant need to shift from providing affordable diagnostics, prevention commodities and medicines for millions to billions, threats to commodity security multiply. This will be acutely felt in the AIDS response where an estimated 6% of people receiving first-line antiretroviral treatment need to shift to second-line regimens each year, and eventually to third-line which is significantly more expensive. Market-driven research and development (R&D) often fails to develop goods for people without the means to pay, or don’t represent a large enough market; TRIPS flexibilities are insufficiently applied while efforts to include TRIPS+ provisions in bilateral and regional trade agreements further circumscribe generic competition and access. Despite such restrictions, Africa has become overly dependent on Indian generics, particularly in relation to HIV treatment. Although political commitments to regulatory harmonization and enhancing local production have been made, progress is slow. In this context, new models to stimulate innovation on research, development, local manufacturing and commercialization are needed—for Africa and elsewhere.
UNAIDS 2011-2015 Strategy: Progress and gaps

In 2010, UNAIDS Board endorsed a Vision for the future of the response. The Vision of zero new HIV infections, zero discrimination, zero AIDS-related deaths, quickly captured the imagination of global leaders, national AIDS councils, community NGOs and activist networks at all levels. Bold, short and memorable, the “Three Zeros” have been frequently cited in speeches of the UN Secretary-General, Presidents, Prime Ministers, and heads of UNAIDS’ Cosponsoring organizations as well as other partners in the AIDS response. The Vision was adopted as the theme of World AIDS Day for 2011 and 2012 and inspired similar visions to be adopted by the tuberculosis and malaria responses.

While the Vision of the Three Zeros is aspirational, the journey towards its attainment was set out through a series of concrete milestones for 2015 in the UNAIDS 2011-2015 Strategy: ‘Getting to Zero’. UNAIDS, with its Board, partners and stakeholders, delivered a Strategy to transform and guide the global AIDS response as well as the specific contributions of UNAIDS. The Strategy emerged from several months of intensive multi-stakeholder consultation and negotiation and was endorsed by UNAIDS’ Board in December 2010. It sought to focus the global response on ten ambitious, results-oriented goals—a limited number that represent the areas where progress was most needed. The Strategy elevated the issue of advancing human rights and gender equality as a guiding strategic direction, alongside revolutionizing HIV prevention and catalyzing a new phase of treatment.

UNAIDS’ Vision and 2011-2015 Strategy brought clarity of purpose and a fresh approach to the Joint Programme, set the global agenda, fostered renewed political commitment and provided a framework for national priority-setting. The Strategy was embraced as a key reference document in the development of the 2011 UN General Assembly Political Declaration on HIV and AIDS, the latter adopting much of the strategic focus and ambitious goals for 2015 put forth by the Strategy.

Significant progress has been achieved in the AIDS response. Annex 2 summarizes progress towards the 10 goals of the UNAIDS Strategy. A few highlights are presented here.

Since 2001, new HIV infections have fallen by 38% - to 2.1 million new HIV infections in 2013 (15 countries accounted for 75% of these new infections, Fig. 5). New infections among children have fallen by 58%, dropping below 200,000 in the 21 most affected countries in Africa for the first time. This is a significant milestone on the journey to an AIDS-free generation.

Countries are also starting to discuss self-testing as another tool to prevent HIV transmission. France is “completing its arsenal” of tools to address HIV by allowing pharmacies to sell HIV self-tests. In high-prevalence regions of the world, voluntary medical male circumcision is being rapidly scaled up to reduce the risk of men acquiring HIV through heterosexual sex by up to 60%.

Record numbers of people (13.6 million) are accessing life-saving antiretroviral medicines, contributing to steady declines in the number of AIDS-related deaths and further buttressing efforts to
prevent new infections. Thailand recently became the first country in Asia to offer life-saving treatment to everyone. The scale-up of collaborative HIV/TB activities (including HIV testing, ART and recommended preventive measures) prevented 1.3 million people from dying from 2005 to 2012.

While many countries remain reliant on international resources, the response is moving towards sustainability: The majority of global AIDS resources—which were almost US$ 19 billion in 2012—are now coming from domestic sources in low- and middle-income countries.

**Fig. 5 Proportion of new HIV infections by country, 2013**

Gaps in the response: Populations being left behind

The people who have not yet been linked to HIV testing, information, prevention and treatment services are the most difficult to reach, suggesting that innovative and diverse approaches are needed to sustain and accelerate recent trends. Some populations are at higher risk or lack access to effective services because they are marginalized, others because of harmful laws, policies and gender norms, poverty, legal and social inequalities. Across regions, the populations being left behind vary greatly (Fig. 6), as do the contextual factors that result in their vulnerability and marginalization. The 2014 UNAIDS Gap Report explores issues faced by 12 populations that have been left behind by the AIDS response.

Of the 35 million people living with HIV in the world, 19 million do not know their HIV-positive status. Adolescent girls and young women account for one in four new HIV infections in sub-Saharan Africa. Three of four children living with HIV or 76% are not receiving HIV treatment. Prisoners are much more vulnerable to HIV, tuberculosis and hepatitis B and C – up to 50 times – than the general public, and are often denied access to relevant health services.

Between 40-50% of all new infections worldwide are currently estimated to occur among key populations (sex workers, men who have sex with men, people who inject drugs and transgender people) and their sexual partners. Only about three fifths of countries have risk reduction programmes for sex workers, while access to HIV prevention services remains low among gay men and other men who have sex with men; 88 countries report that fewer than half of men who have sex with...
men know their HIV status from a recent test result. Globally, less than 8% of **people who inject drugs** have access to opioid substitution therapy, and 4% of eligible people who inject drugs are receiving ART.

While many countries restrict access to health services for **migrants**, often migrants are simply not able to afford services because of their legal status or income earnings. Yet migrants and their partners are at high risk: In India for example, more than 75% of women testing HIV-positive had a migrant husband.

Many **transgender people** experience social exclusion and marginalization because of the way in which they express their gender identity, and are 49 times more likely to acquire HIV than all adults of reproductive age.

Whether or not they are living with HIV, **people with disabilities** have an unmet need for health and HIV services in order to protect themselves. They represent one of the largest and most underserved populations. The number of people living with HIV in low- and middle-income countries **aged 50 or older** continues to grow, representing 12% of all adult people living with HIV in 2013. However, few HIV strategies in low- and middle-income countries have caught up with this trend.

Too often people at higher risk or living with HIV face multiple issues—such as being a young woman **displaced from home** and engaged in sex work, or a gay man who injects drugs. Ensuring that no one is left behind means closing the gap between people who can get services and people who can’t, the people who are protected and the people who are punished.

**Fig. 6 The importance of location and population**
Fast-Tracking to 2021: Location, population and innovation

Fast-Tracking will set us on the path towards ending AIDS

The AIDS response can be ended as a global threat by 2030. This confidence is based on a combination of major scientific breakthroughs and accumulated lessons learned in scaling up the AIDS response worldwide. Today we know that HIV treatment can dramatically extend the lifespan of people living with HIV and effectively prevent HIV transmission. There are also many proven opportunities for HIV prevention beyond medicines, including condom programming, behaviour change, voluntary medical male circumcision and programmes to empower key populations to reduce HIV risk. These have clearly demonstrated their capacity to sharply lower rates of new HIV infections. HIV programmes are further dramatically strengthened when they are combined with social and structural approaches.

We know what works – but to reach our targets\(^{11}\) for 2020 and set ourselves on a path towards ending AIDS by 2030, countries and their partners will need to significantly ramp up investments, programmes and policy change, and focus on populations, locations and innovation.

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\(^{11}\) Over the course of 2014, all seven UNAIDS regions completed regional consultations on country and regional target setting. These consultations primarily focused on setting HIV treatment targets for beyond 2015 and also included other AIDS response targets. From these consultations, guided by evidence, modelling and implementation science, a clear call for the Fast-Track targets emerged.
Fig. 7 Estimated annual number of new HIV infections and AIDS-related deaths in low- and middle-income countries, by region: Comparing the achievement of the Fast-Track Targets and maintaining 2013 coverage levels

**WEST AND CENTRAL AFRICA**

- **New HIV infections**
- **AIDS-related deaths**

Comparing the achievement of the Fast-Track Targets and maintaining 2013 coverage levels

**CARIBBEAN**

- **New HIV infections**
- **AIDS-related deaths**

Comparing the achievement of the Fast-Track Targets and maintaining 2013 coverage levels

**LATIN AMERICA**

- **New HIV infections**
- **AIDS-related deaths**

Comparing the achievement of the Fast-Track Targets and maintaining 2013 coverage levels
What will it take to reach the Fast-Track targets?

There will be no ending AIDS without putting people first, without ensuring that people living with and affected by the epidemic are part of a new movement. Without a people-centred approach, we will not go far in the post-2015 era.

So what will it take to reach our targets, and how do we close the gap between the people moving forward and the people being left behind? To catalyze a discussion on “doing things differently” through the UNAIDS Strategy 2016-2021, an illustrative set of opportunities and innovations for accelerating progress are presented below:

- **Going granular**: Responses must increasingly prioritize focusing on the areas where the HIV epidemic is highly concentrated, and identifying the places where services are lacking or not reaching the people in need of prevention services, testing, treatment and support. Data collection methods that map behavioural risks, such as high rates of injecting and syringe-sharing, as well as rates of sexually transmitted infections can help to localize responses in relatively small, discrete areas that could be serviced with HIV treatment and prevention packages (such as needle and syringe programmes, opioid substitution therapy, ART and TB hepatitis C treatment). **Mobilizing and empowering local leaders**, including Mayors, to champion “going granular” by demanding and implementing city-specific interventions will be critical.

- Ensuring **clearer accountability for front-loading investments**, achieving financial sustainability and mobilizing resources from both traditional and emerging development partners as well as domestic sources.

- Addressing and protecting the **needs and rights of those most affected and marginalized**, and adequately monitoring progress on reaching those populations who continue to be left behind – including by supporting data collection by representatives from networks of key populations. This can ensure that the data are gathered and used in ways that do not expose key populations to discrimination, harassment or persecution.

- Removing **social and legal barriers** that prevent young people—in particular young women and girls and key populations—from accessing comprehensive, integrated sexual and reproductive health and HIV education, prevention, treatment, care and support services.

- **Addressing harmful gender norms and guaranteeing the rights of women and girls** so that they can protect themselves from HIV and gain greater access to treatment and care, including by amplifying the voices of women in decision-making, addressing the intersections between HIV and violence against women, and promoting access to justice for women living with and affected by HIV, including their access to property and inheritance rights.

- While consolidating significant gains, **enhance focus on under-performing countries**, for example, address bottlenecks, stagnating pace of progress and lost ground in several countries in implementing the **Global Plan to Eliminate New HIV Infections Among Children and Keep their Mothers Alive**.

- **Empowering civil society**: Civil society organizations currently receive only 1% of global AIDS funding. UNAIDS proposes this proportion be increased to at least 3% to effectively leverage the role and contributions of community- and peer-led civil society organizations.
Encouraging countries and regional and global partners to move forward on the ‘AIDS out of isolation’ agenda, in terms of:

- Expanding linkages at policy, systems and service delivery levels
- Pursuing multisectoral solutions to address shared determinants across health issues e.g. social protection – recent evidence indicates that social protection can play a role in preventing new HIV infections and improving adherence to treatment
- Leveraging the potential of the AIDS response to negotiate and deliver global public goods – including disease surveillance systems, affordable, quality-assured medicines, and the global norm of health as a political and economic priority

Close

By committing to Fast-Track the AIDS response, countries, regions, and the global community have demonstrated an unprecedented level of ambition, hope and dedication. Reaching the Fast-Track targets in the 2016-2021 period is possible - but will require us to collectively respond to several fundamental questions. We have identified those posed at the opening of this paper as a good starting point:

1. **How will developments – globally and in the region – impact the epidemic and response in the region, sub-regions and specific countries over the next six years?**

2. **What achievements of the regional response should be expanded and built upon? Where are the main challenges and gaps? Who is being left behind and why?**

3. **In order to reach the Fast-Track targets, what should be the region’s strategic priorities in the response?**

4. **What will need to change in support of those priorities? What are the “game-changers” – in terms of policy and law reform, funding, resource allocation, partnerships, service delivery, empowering civil society, science and innovation, and links with other health and development efforts?**

5. **What are the most critical ways in which the UNAIDS Joint Programme can support efforts in the region to end AIDS as a public health threat by 2030?**

By collectively exploring and defining the answers to these questions, and translating them into an actionable Strategy, together we can set the world on course to Fast-Tracking the AIDS response, and ending the epidemic by 2030.

For more information, contact the Strategy Development Team: Strategydevelopment@unaid.org
Annex 1. **CURRENT Strategic directions, objectives and impact areas of the UNAIDS Strategy 2011-2015**

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<th>VISION STRATEGIC DIRECTIONS</th>
<th>ZERO NEW HIV INFECTIONS</th>
<th>ZERO AIDS-RELATED DEATHS</th>
<th>ZERO DISCRIMINATION</th>
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<tr>
<td>OBJECTIVES</td>
<td>Revolutionize HIV prevention</td>
<td>Catalyse the next phase of treatment, care and support</td>
<td>Advance human rights and gender equality for the HIV response</td>
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<tr>
<td>To generate political commitment on how and why people are getting infected</td>
<td>To mobilize communities to demand transformative change</td>
<td>To ensure that people living with HIV can access treatment</td>
<td>To support countries in protecting human rights in the context of HIV</td>
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<tr>
<td>To direct resources to epidemic hot spots</td>
<td>To strengthen national and community systems to deliver services</td>
<td>To scale up access to care, support and social protection services</td>
<td>To advance country capacity to reduce stigma and discrimination</td>
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<tr>
<td>IMPACT AREAS</td>
<td>Leaders positively incentivized to make the right decisions</td>
<td>Strategies emphasize priority prevention programmes</td>
<td>To ensure that national programmes address the needs of women and girls</td>
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<tr>
<td>Standards</td>
<td>Young people empowered to reassert harmful social norms</td>
<td>Better drugs and point-of-care tools developed</td>
<td>Care and support services adapted to diverse needs</td>
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<td>Political and legal barriers mapped and addressed</td>
<td>Strategies emphasize priority prevention programmes</td>
<td>Capacity of community systems to deliver integrated services expanded</td>
<td>Key populations empowered to claim their rights</td>
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<td>Positive Health, Dignity and Prevention approaches scaled up</td>
<td>Innovative and effective prevention approaches introduced and scaled up</td>
<td>Care and support services adapted to diverse needs</td>
<td>People living with HIV mobilized as forces of change</td>
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<td>Major non-drug-related cost savings identified and achieved</td>
<td>Country capacity for registering of medicines and using TRIPS scaled up</td>
<td>HIV-sensitive social transfers embedded into national programmes</td>
<td>Programmes that support women and girls across the full range of their lives implemented</td>
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<tr>
<td>HIV-sensitive social transfers embedded into national programmes</td>
<td>Guidance on protective social and legal environments in HIV context disseminated</td>
<td>Data collection with people at higher risk of HIV infection strengthened and put to use</td>
<td>Programmes to counter gender-based violence implemented</td>
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<td>CORE THEMES</td>
<td>Inclusive, country-owned sustainable responses</td>
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<td>Build and strengthen lasting local institutional capacity</td>
<td>Mobilize national leaders to allocate funding, including domestic, to those at the highest risk of infection with the most cost-effective interventions</td>
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<td>People at the centre of the response</td>
<td>Promote the leadership and capacity of peer-led organizations and networks of people living with and affected by HIV and at higher risk of HIV infection in designing, implementing and evaluating HIV responses at the global and national level</td>
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<tr>
<td>Synergies between the HIV response and broader Millennium Development Goals and human development efforts</td>
<td>Generate collaboration between various networks and movements promoting health and development causes</td>
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<tr>
<td>Leverage resources for implementing appropriate, equitable and cost-effective approaches to integrating programmes and services</td>
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## PROGRESS (2013; Baseline 2009)

<table>
<thead>
<tr>
<th>Sexual transmission of HIV reduced by half, including among young people, MSM and transmission in the context of sex work</th>
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</thead>
<tbody>
<tr>
<td>New adult infections continue to decline in most parts of the world: 10% since 2009/10, 1,900,000 new infections, 47% in females</td>
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<tr>
<td>Highly effective biomedical tools have emerged</td>
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<tr>
<td>Adult key populations(^{12}) account for 40-50% of new infections. Prevalence among SWs is 12x greater than women overall; Among MSM about 19x greater than men generally</td>
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<table>
<thead>
<tr>
<th>GAPS</th>
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<tbody>
<tr>
<td>15 countries account for more than 75% of new HIV infections</td>
</tr>
<tr>
<td>Low progress in reducing transmission related to sex work and among MSM</td>
</tr>
<tr>
<td>In some regions young women and girls at higher risk of HIV than male peers. 80% of young women living with HIV are in SSA</td>
</tr>
<tr>
<td>Weak implementation of quality Comprehensive Sexuality Education.</td>
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<tr>
<td>HIV burden varies greatly by location and population</td>
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<tr>
<td>VMMC burden varies greatly by location and population</td>
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<table>
<thead>
<tr>
<th>All new HIV infections prevented among people who use drugs</th>
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<tbody>
<tr>
<td>Little change in HIV burden: 12.7 million people inject drugs and 13% of them are PLHIV</td>
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<tr>
<td>HIV prevalence is 22 times higher among people who inject drugs than the general population</td>
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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Programmatic coverage is low</td>
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<tr>
<td>Numerous countries retain punitive policy and legal frameworks/practices which discourage individuals from seeking health and social services</td>
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<tr>
<td>The HIV prevalence among people injecting drug is higher for women (13%) than men (9%)</td>
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<table>
<thead>
<tr>
<th>Vertical transmission of HIV eliminated and AIDS-related maternal mortality reduced by half</th>
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</thead>
<tbody>
<tr>
<td>43% reduction of new HIV infections in children</td>
</tr>
<tr>
<td>Among 21 highest-burden countries, eight countries reduced infections by 50% or more</td>
</tr>
<tr>
<td>PMTCT coverage increased from 33% to 68% - and with more efficacious regimens</td>
</tr>
<tr>
<td>Down to 7,500 maternal deaths attributable to AIDS(^{13})</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>GAPS</th>
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<tbody>
<tr>
<td>Need for similar scale-up of other prevention strategies, including primary HIV prevention for women and access to contraception and other family planning services</td>
</tr>
<tr>
<td>Greater efforts needed to link pregnant women and children to HIV treatment and care, and continuity care for women on ART through breastfeeding</td>
</tr>
<tr>
<td>About 30% of countries have yet to integrate PMTCT in antenatal care and SRH services</td>
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<tr>
<td>Lack of child-friendly regimens</td>
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<thead>
<tr>
<th>Universal access to ART for people living with HIV who are eligible for treatment</th>
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<tbody>
<tr>
<td>On track to reach the goal: 13.6 million people on ART as of June 2014</td>
</tr>
<tr>
<td>AIDS-related deaths decreased by 25% (1.5 million deaths)</td>
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<thead>
<tr>
<th>GAPS</th>
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<tbody>
<tr>
<td>38% of adult PLHIV on ART compared to 24% of children</td>
</tr>
<tr>
<td>Considerable variation in ART access within and among regions</td>
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<tr>
<td>Need for greater attention to both uptake and adherence support measures</td>
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<tr>
<td>Roughly half of PLHIV in SSA know their status</td>
</tr>
<tr>
<td>Lack of access to 2(^{nd}) and 3(^{rd}) line drugs</td>
</tr>
</tbody>
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\(^{12}\) Sex workers and their clients, men who have sex with men, transgender people and people who inject drugs and their sexual partners

\(^{13}\) Due to adjustments in calculation it is not possible to compare estimates over time
TB deaths among people living with HIV reduced by half

- TB-related deaths among PLHIV declined by 33% worldwide since 2004
- TB is the leading cause of death among PLHIV (360,000 deaths)
- People with HIV/TB on isoniazid therapy is a fraction of those in need
- 50% of countries have either fully integrated HIV and TB services or strengthened joint service provision

People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support

- A trend towards integration of HIV with diverse systems and sectors is apparent
- Good country examples of HIV-sensitive social protection programmes, such as India and Tanzania
- Social protection care and support for PLHIV is underfunded and fragmented, and limited in scope and coverage
- Data on the level at which social protection instruments are HIV sensitive not readily available
- Orphans school attendance rate is still lower (90%) than for non-orphans

Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half

- Work on this goal has substantially increased political commitment, partnerships, and evidence informed programmes to remove punitive laws and reduce stigma and discrimination
- Evidence-base on impact of punitive laws on HIV has been expanded
- The number of countries with obstacles to effective responses has not fallen (60%). Criminalization of key populations remains widespread.
- Discriminatory treatment of people living with HIV remains common in multiple facets of life, including access to health care

HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions

- Since 2011, 10 countries removed restrictions
- 38 countries have travel restrictions
- Middle East and North Africa region continues to have the highest number of countries that impose HIV-related travel restrictions

HIV-specific needs of women and girls are addressed in at least half of all national HIV responses

- Above 80% of countries report that gender issues are included in their Multisectoral HIV Strategies, with 50% having an earmarked budget
- Gender inequalities and harmful gender norms continue to contribute to HIV-related vulnerability
- Less than half of countries allocate funds for women’s organizations
- Reports from all regions on cases of forced or coerced sterilization against women living with HIV

Zero tolerance for gender-based violence

- More than 80% of countries have a policy, law or regulation to reduce violence against women
- Intimate partner violence is prevalent in all regions – although with large ranges/variations
- Violence against sex workers is prevalent

Close the global AIDS resource gap and reach annual global investment of US$22-24 billion in low- and middle-income countries (2011 UNGA Political Declaration Target)

- US$ 19.1 billion invested in AIDS programs in low- and middle-income countries; just over a 10% increase from 2011
- Lower-middle and low-income countries contribute 22% and 10% of AIDS investments from domestic sources
- HIV expenditures require significant efficiency reallocation and cost containment to become investments and thus gain return of investment greater than 1.

## Annex 3: Select contributions of the Joint Programme to global progress towards the UNAIDS 10 Strategy Goals\(^{14}\)

<table>
<thead>
<tr>
<th>Sexual transmission of HIV reduced by half, including among young people, MSM and transmission in the context of sex work</th>
<th>The Joint Programme reinforced the importance of location and population for effective prevention by mapping gaps and populations left behind. It led analyses and reviews of national responses to contextualise global findings; promote evidence-informed combination prevention and integrate new technologies. In 2013, WHO pre-qualified the first nonsurgical circumcision device for adults and considerable gains were made in scaling up Voluntary Medical Male Circumcision. UNDP and UNFPA have supported 26 cities covering five regions to develop innovative municipal HIV Action Plans addressing the needs of key populations. UNESCO-led efforts to advance education for HIV prevention and sexual and reproductive health issues have yielded promising results. UNFPA re-energized condom programming and addressed gaps in availability through national CONDOMIZE! campaigns in 5 countries, and procurement of 1.1 billion male condoms and 21 million female condoms. In 2014, UNICEF and the UNAIDS Secretariat, with engagement of all Cosponsors, initiated the All In! agenda, aimed at reducing new HIV infections among adolescents by at least 75%, and increasing the number of adolescents on lifesaving treatment to 80%. WFP’s school feeding programmes drive girls’ attendance and pre-empt the adoption of negative coping mechanisms that increase the risk of HIV infection, such as transactional sex.</th>
</tr>
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<tbody>
<tr>
<td>All new HIV infections prevented among people who use drugs</td>
<td>UNODC placed HIV and drug use at the heart of its global agenda, and led UNAIDS to support an increase in access for women and men who inject drugs to harm reduction services including in prisons. The Joint Programme provided guidance on preventing HIV transmission among people who inject drugs, including those under 18 or in prisons. Legislative guidance and policy analyses contributed to legal reforms for drug-related services in Azerbaijan, Cambodia, Uzbekistan and Vietnam. Law enforcement officers were trained in 18 countries on supportive practices to enable access to harm reduction services.</td>
</tr>
<tr>
<td>Vertical transmission of HIV eliminated and AIDS-related maternal mortality reduced by half</td>
<td>The Joint Programme leads the global campaign to eliminate new HIV infections among children. The Global Plan to Eliminate New HIV Infections Among Children and Keep their Mothers Alive, co-led by the UNAIDS Secretariat and PEPFAR, has united countries around a single objective, mobilised science and innovation, accelerated country level action and strengthened accountability. UNICEF and WHO co-lead the Secretariat of the 32-partner Inter-Agency Task Team that coordinates technical assistance, guidance and tools development, and tracking of progress on the Global Plan. WHO’s improved global guidance (life-long treatment or Option B+ which provides that pregnant women with HIV should be maintained on treatment for life) made interventions more effective in averting new infections. At country level, the Joint Programme provides extensive technical assistance to ensure that national plans are in place, resources available, approaches integrated – including with food security efforts to retain mothers in care – and decentralised and local capacities improved.</td>
</tr>
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\(^{14}\) 2011-2013; Information from 2014 has been included but it is incomplete.
| Universal access to ART for people living with HIV who are eligible for treatment | The Treatment 2015 initiative was launched in 2013 by the UNAIDS Secretariat, WHO, the GFATM and PEPFAR to accelerate treatment scale-up and intensify financial and technical support to 30 countries that account for 90% of the global unmet need for treatment. In 2013, WHO issued consolidated treatment guidelines and supported countries to adapt and implement them. These guidelines are having tremendous impact on access to quality treatment services. UNHCR provided treatment to refugees while lobbying for their inclusion in national programmes. In 2014, UNDP-supported Global Fund programmes helped 1.4 million people access life-saving ART. ILO and UNAIDS launched the VCT@WORK Initiative to scale up HIV testing in high impact countries, reaching to date approximately 700,000 women and men workers.

The Joint Programme is instrumental for children and key populations to access HIV testing and treatment by continuous advocacy, specific guidance and increased allocation of resources, including via the GFATM. In 2013, UNICEF, with WHO and EGPAP launched Double Dividend to expand testing and paediatric ART through greater alignment with maternal and child survival programming in high burden countries. |
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<tbody>
<tr>
<td>TB deaths among people living with HIV reduced by half</td>
<td>Norms, standards and tools continue to be developed by the Joint Programme. WHO TB/HIV policy was disseminated to 49 countries via workshops and joint TB and HIV programming was undertaken through Global Fund processes. Collaboration with governments and stakeholders brought progress in including food and nutrition in HIV and TB strategies. The WFP’s HIV and TB operations in 2012 &amp; 2013 reached an estimated 2.9 million beneficiaries.</td>
</tr>
</tbody>
</table>
| People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support | The Joint Programme strongly advocated for strengthening HIV integration with other health and development sectors and supported countries to maximize and synergize on the AIDS response achievements. WHO’s 2013 consolidated treatment guidelines promote integrated services such as HIV and TB; PMTCT and ANC; and reproductive, maternal, new-born and child health.

The Joint Programme led evidence-based advocacy for HIV-sensitive social protection, facilitated research, and provided technical support to government, civil society and private sector to expand coverage and depth. In 2012-13, with total funding for social protection reaching almost US$ 15 billion and a new Strategy for Africa, the World Bank played a key role in strengthening national systems and integrating HIV across social protection schemes. WFP provided food assistance to offset economic shocks of impact HIV-affected households, and linked to broader social protection platforms and economic strengthening activities. UNICEF is working with governments and partners across Africa to scale up the coverage of national social protection programmes to reduce HIV infection among adolescents, keep adolescents on treatment, and increase the resilience of poor and vulnerable households and children affected by HIV. |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
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<tbody>
<tr>
<td>Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half</td>
<td>In addition to global high-level advocacy and policy statements, joint action was undertaken in 84 countries to advance the recommendations of the Global Commission on HIV and the Law, convened by UNDP on behalf of UNAIDS. The Joint Programme has helped countries draft legislation and policies, based on public health evidence and human rights principles, and convened consultations on laws, including in the context of key populations and young people. Dialogues on HIV and the law were held in 49 countries, with the Joint Programme helping 65 countries undertake legal environment assessments and reviews. UNAIDS and partners developed advocacy and guidance materials. Fifty countries completed the PLHIV Stigma Index, which has promoted and informed national dialogue on improving legal and social environments for effective AIDS responses. In 2014 WHO released recommendations of evidence-based, targeted HIV policies and programmes focused on all five key population groups currently identified as the groups most vulnerable to HIV. ILO published an HIV handbook for judges, magistrates, lawyers and parliamentarians from 50 countries. Capacity building led to national legislative and HIV workplace policy reviews in dozens of countries.</td>
</tr>
<tr>
<td>HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions</td>
<td>The Joint Programme has a) identified where travel restrictions exist, b) carried out high-level advocacy to lift such restrictions, and c) provided concrete technical assistance for the removal of the discriminatory provisions. In several countries, the UNAIDS Secretariat created momentum for the removal of restrictions and built partnerships that were able to carry the issue forward.</td>
</tr>
<tr>
<td>HIV-specific needs of women and girls are addressed in at least half of all national HIV response</td>
<td>The Joint Programme implemented the Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV in more than 90 countries and produced strategic guidance on gender and HIV. A review of the Agenda found that “nearly two thirds of countries strengthened gender equality within their AIDS responses, and gains were made in fostering political commitment and developing an evidence base for policies and programmes”. More than 700 civil society organizations are implementing the Agenda. By supporting women networks, UNDP, UN Women and the UNAIDS Secretariat help women living with HIV to influence HIV planning and implementation and increase their access to justice. Since 2011, UN Women has supported several sub-Saharan African countries to improve legal and property inheritance rights for women and girls living with HIV with clear results in the increase in availability and accessibility of legal services. UNFPA helped build consensus on best practices for protecting and supporting the adolescent girl-child.</td>
</tr>
<tr>
<td>Zero tolerance for gender-based violence</td>
<td>Activities on Gender Based Violence (GBV) are wide-ranging. In 2011, the UN Security Council adopted Resolution 1983 on preventing HIV and GBV in conflict settings – an agenda driven by UNAIDS. It helped document the linkages between HIV and GBV using social media to raise awareness; evidence and technical support on the linkages between GBV, food security and HIV (WFP); advocacy and country efforts to address GBV in the context of sex work (UNDP, UNFPA). The UN Women Gender Equality Fund provides direct grants to CSOs, which have forged effective partnerships addressing intersections of violence against women and HIV at the community level. The IATT on Education, led by UNESCO and in collaboration with UN Women and UNGEI, is advancing evidence and research on school-related gender-based-violence and producing regional and global guidance to assist national stakeholders in developing educational policies and practices that promote safe schools for all young people. UNFPA and partners published an Asia-Pacific assessment of the impact of violence against sex workers on HIV risk and engaged multiple sectors in response to this.</td>
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Annex 4. Towards zero discrimination: Proposed global non-discrimination targets (DRAFT)

Ending stigma and discrimination are both a condition and a goal in our efforts in ending the AIDS epidemic by 2030. Effective measures to end stigma, discrimination and other human rights violations against people living with HIV, key populations and other affected populations through policy and programmatic actions must focus on:

- Enabling legal and policy environments, in line with the recommendations of the Global Commission on HIV and the Law, by removing punitive laws, and putting in place processes that promote equal participation and input by all, including men, women, girls, boys and transgender people, in formulation of such laws and policies. Promotion of systemic measures to ensure equality and eliminate stigma and discrimination, providing effective and transparent legal protection and mechanisms that promote access to justice and appropriate redress for rights violations;

- Agency, organising and giving a voice to people living with HIV, key populations and other affected populations, that support the ability of individuals to know, assert and claim their rights and meaningfully engage in policy development in order to reduce and overcome HIV vulnerabilities and barriers to accessing HIV services, as well as to seek and obtain redress for human rights violations; and

- Inclusive social environments providing equal rights and opportunities that support the transformation of negative norms, attitudes and stereotypes, power imbalances hindering gender equality, and where people living with HIV, key populations and other affected populations are accepted within communities; are able to make decisions that affect their lives; have access to health, employment, education and social services; and have equal opportunities to be active and productive members of their communities and citizens of their countries.

Efforts to develop non-discrimination targets highlight the need to cover structural, legal and socio-cultural factors that create or reinforce risks and vulnerability to HIV. They also take into consideration factors that affect the availability, accessibility, acceptability, quality, and equality in access to HIV and SRH services and information for women, girls and other key populations using a lifecycle approach ensuring inclusion from childhood into adulthood.

Proposed global non-discrimination outcome target: By 2020, no one, nowhere, is subject to discrimination because of real or perceived HIV status

Proposed programmatic targets, by 2020:

1) No new HIV-related discriminatory laws, regulations and policies are passed, and 50% of countries that have such laws, regulations and policies repeal them

2) Less than 10% of people living with HIV, key populations and other affected populations experience discrimination, harassment or violence, including because of gender, gender-identity, sexual orientation, drug use, sex work, or age

3) No one experiences denial of health services because of real or perceived HIV status and less than 10% of healthcare providers report discriminatory attitudes towards people living with HIV, key populations and other affected populations.

4) 90% of people living with HIV, key populations and other affected populations who report experiencing discrimination have access to justice and can challenge rights violations.
ANNEX 5. Update on regional epidemic and response (*To be completed by RST*)