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HIV PREVENTION IN THE AFRICAN REGION: A STRATEGY FOR RENEWAL AND ACCELERATION

Report of the Regional Director

EXECUTIVE SUMMARY

1. Nearly two thirds of the world's HIV-positive population live in sub-Saharan Africa. In 2005 alone, out of the 4.9 million new infections, 3.2 million occurred in the African Region, the majority of those affected being aged between 15 and 49.

2. Countries in the African Region have made encouraging progress in implementing various elements of prevention and treatment interventions to control the HIV/AIDS epidemic. The main challenges include limited effective coverage of services in order to have the required impact, weak linkage between prevention and treatment interventions, weak health systems, lack of favourable policy environment for HIV prevention and inadequate resources at all levels.

3. Recognizing the alarming trend in HIV incidence in the Region and the need to increase measures to control further progress of the epidemic, the WHO Regional Committee for Africa, at its fifty-fifth session in August 2005, adopted Resolution AFR/RC55/R6, "Acceleration of HIV prevention efforts in the African Region". By that resolution, the Regional Committee declared 2006 the "Year for Acceleration of HIV Prevention in the African Region" and urged Member States to re-emphasize and re-invigorate HIV prevention efforts.

4. The main objective of this strategy is to contribute to the acceleration of HIV prevention and to the reduction of the impact of HIV/AIDS in the context of universal access to prevention, treatment, care and support. The strategic approaches proposed focus on scaling up access to prevention interventions and integrating prevention with treatment, care and support.

5. The Regional Committee is requested to review and adopt this proposed strategy along with the attached resolution.

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INTRODUCTION

1. The regional HIV strategy adopted in 1996 during the forty-sixth session of the WHO Regional Committee for Africa reaffirmed the major role of the health sector in national response to the HIV/AIDS epidemic with a clear prevention component.[1] In spite of the resources and efforts invested, the epidemic has continued unabated, with high morbidity and mortality, undermining health gains and the improvement of health status in the Region.

2. HIV prevention efforts have been outpaced by the HIV/AIDS epidemic, with a rising trend of HIV incidence in most countries. Should the current trends continue, most countries in the African Region are unlikely to achieve Millennium Development Goal No 6.[2] It is therefore imperative to reshape strategies of prevention, identify measures to quickly scale up successful interventions and highlight what should be done differently.

3. Recognizing the alarming trend in HIV incidence in the Region and the need to increase measures to control further spread of HIV, the WHO Regional Committee for Africa at its fifty-fifth session, held in Maputo in August 2005, adopted Resolution AFR/RC55/R6, "Acceleration of HIV prevention efforts in the African Region". By that resolution, the Regional Committee declared 2006 the "Year for Acceleration of HIV Prevention in the African Region" and urged Member States to urgently re-emphasize and re-invigorate HIV prevention efforts, establish stronger partnerships and coordination mechanisms, and ensure effective leadership and coordination.

4. Current global initiatives and commitments provide an enabling environment to scale up prevention efforts in the Region while ensuring linkages to treatment, care and support interventions. In June 2005, UNAIDS approved a policy position paper, "Intensifying HIV prevention".[3] Similarly, the Gleneagles G8 Summit of July 2005 made a commitment to provide support to countries for achieving universal access to prevention, care and treatment for all those who need it by 2010.[4]

5. Recognizing that there were insufficient resources to protect and save children, UNICEF, with its partners, launched a global campaign under the theme: "Unite for children, unite against AIDS". The campaign seeks to place children infected and affected by HIV/AIDS at the centre of the global response through focused efforts to scale up prevention and care interventions.[5]

6. In March 2006, representatives of 53 African countries adopted the "Brazzaville Commitment" calling on countries to take urgent and bold action to address the bottlenecks that impede progress in the implementation of prevention, treatment, care and support services.

7. This document proposes key interventions and actions for accelerating HIV prevention interventions in the health sector and highlights the linkages to treatment, care and support

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[1] Resolution AFR/RC46/R2, Strategy on HIV/AIDS/STD prevention and control in the African Region. In*: Forty-sixth Session of the WHO Regional Committee for Africa, Brazzaville, Congo 4–11 September 1996, Final Report*. Brazzaville, World Health Organization, Regional Office for Africa, 1996 (AFR/RC46/18), p.5.

[2] The Millennium Development Goals Report 2005. http://unstats.un.org/unsd/mi/pdf/MDG%20Book.pdf (last accessed 12-04-2006).

[3] Scaling up towards universal access. UNAIDS http://www.unaids.org/en/in+focus/topic+areas/universal+access.asp (last accessed 12-04-2006).

[4] The Gleneagle Communiqué http://www.fco.gov.uk/Files/kfile//PostG8_Gleneagles_Communique,0.pdf (last accessed 12-04-2006).

[5] Calling attention to the impact of HIV/AIDS on the African family. Fourteenth ICASA Conference http://www.unicef.org/uniteforchildren/youth/youth_30394.htm (last accessed 12-04-2006).

interventions within the context of universal access. However, effective implementation of this strategy requires multisectoral involvement and coordination.

SITUATION ANALYSIS

8. At the end of 2005, of the estimated 40 million people living with HIV/AIDS, 25.8 million were in sub-Saharan Africa.[6] According to the WHO-UNAIDS report of December 2005, of the 4.9 million new infections, worldwide, 3.2 million (65%) occurred in sub-Saharan Africa, with an overall prevalence of 7.2% (6.6%–8.0%). During the same year, an estimated 2.4 million adults and children died, and more than 12 million children were orphaned due to AIDS. Now the leading cause of death for both children and adults, AIDS has reduced average life expectancy from 62 years to 47 years[7] in the African Region.

9. Prevention, like treatment, remains concentrated in urban areas. Vulnerable groups are inadequately targeted, fuelling the epidemic. Prevention would be more effective if closely coordinated with treatment, care and support interventions. It has been shown that HIV prevention is cost-effective and that implementation of a comprehensive HIV prevention package (linked to treatment) could avert 29 million (63%) of the 45 million new infections expected to occur in the Region by 2010.[8]

10. In 2003, the proportion of adults receiving voluntary counselling and testing was 7% while the proportion of pregnant women covered by prevention of mother-to-child transmission (PMTCT) services was 5% in sub-Saharan Africa.[9] Coverage of voluntary counselling and testing (VCT) and prevention of mother-to-child transmission services in the region remains among the lowest in the world, estimated at 7% and 5%, respectively.[10] In 2004, condom use with non-cohabiting partners was reported as 19% in sub-Saharan Africa.[11] Of the estimated 4.7 million adults and children in need of antiretroviral drugs in the Region, only 17% received treatment by the end of 2005. [11]

11. Efforts to accelerate HIV prevention interventions and move towards the goal of Universal Access will face a number of challenges:

(a) *Lack of favorable policy environment.* Prevention and care that improve utilization of services and address underlying factors of HIV transmission require an enabling policy environment.

(b) *Low coverage of HIV prevention interventions.* In order to ensure comprehensive coverage at all levels of the health system, HIV prevention intervention will need to be expanded and integrated.

(c) *Weak linkages.* HIV prevention, treatment, care and support interventions should be linked in the context of an "essential package".

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[6] WHO, AIDS Epidemic Update, Geneva, WHO/UNAIDS, December 2005.
[7] Impact of HIV/AIDS on Africa http://www.avert.org/aafrica.htm (last accessed 12-04-2006).
[8] Stover J, Walker N, Garnett GP et al, Can we reverse the HIV/AIDS pandemic with an expanded response? *Lancet*, 360 (9326): 73–77, 2002.
[9] UNAIDS, Report on the global AIDS epidemic, New York, Joint United Nations Programme on HIV/AIDS, 2004.
[10] Anon, Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003, Washington D.C., USAID, UNAIDS, WHO, UNICEF and the POLICY Project, June 2004.
[11] UNAIDS, Report on the global AIDS epidemic, New York, Joint United Nations Programme on HIV/AIDS, 2004.
[11] WHO, Scaling up HIV/AIDS prevention, treatment and care: a report on WHO's support to countries in implementing the "3 by 5" Initiative, April 2006.

(d) *Limited access for target populations*. Participation of the private sector, civil society groups, PLWHAs and all target groups would be ensured by a national public health response to HIV/AIDS.

(e) *Weak health systems*. In order to meet the increased demand for HIV/AIDS prevention, treatment, care and support services, health systems need to be strengthened.

(f) *Inadequate financial resources.* There is a need to mobilize and ensure additional and sustainable financial resources that reach operational levels while ensuring effective coordination and accountability of resources.

12. However, several opportunities exist to scale up comprehensive HIV services with a focus on prevention. They include:

(a) increased commitment at global, regional and country levels for scaling up response to HIV;

(b) existence of the "Three Ones" principle[13] with improved management, coordination, partnerships, monitoring and evaluation;

(c) lessons learned from The 3 by 5 Initiative and sharing of experiences and best practices;

(d) progress in operational and clinical research to inform programmes and generate new preventive and therapeutic alternatives.

OBJECTIVES

13. The main objective is to contribute to the acceleration of HIV prevention and to the reduction of the impact of HIV/AIDS in the context of universal access to prevention, treatment, care and support.

TARGETS

14. By the end of 2010:

(a) All districts will provide counselling and testing services;
(b) 100% safe blood and blood products will be ensured;
(c) at least 80% of pregnant women attending antenatal care will access PMTCT services;
(d) at least 80% of patients with sexually-transmitted infections will access comprehensive STI management;
(e) at least 80% of people living with HIV and AIDS will have access to comprehensive prevention, treatment and care services;
(f) condom use will reach at least 60% in high-risk sexual encounters.

[13] The "Three Ones" principle refers to *one* agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; *one* national AIDS coordinating authority with a broad-based multisectoral mandate; and *one* agreed country-level monitoring and evaluation system.

GUIDING PRINCIPLES

15. The following guiding principles will underpin the acceleration of HIV prevention in the African Region:

(a) ***Human rights approach.*** Equitable access to quality services based on a human rights approach will ensure adequate attention to vulnerable populations, including women, children, particularly those affected by conflicts, the poor, and populations in underserved areas. Issues of sexual violence and deliberate transmission of HIV need to be given due attention.

(b) ***Adaptation of proven interventions.*** Priority should be given to identification, adaptation and scaling up of culturally- and socially-acceptable HIV preventions.

(c) ***Linkages.*** HIV prevention and HIV care, treatment and support interventions should be implemented simultaneously. Every situation in which an individual seeks health care should be an opportunity for HIV prevention.

(d) ***Community participation.*** Communities and civil societies should be promoted and supported as key components in scaling up intervention at all levels. Participation should be from all communities, including PLWHA.

(e) ***"Three Ones" principle.*** Governments should take the lead and, with participation of all stakeholders, update or develop an overall strategic framework for national response, national HIV/AIDS coordination, and national monitoring and evaluation.

(f) ***Sustainability and accountability.*** There is a need to advocate for additional resources, ensure proper disbursement and utilization of resources, and develop a system to monitor appropriate use of funds.

STRATEGIC APPROACHES

16. Accelerating the implementation of HIV prevention services will require decentralized implementation of the strategic approaches set forth below.

Creating an enabling policy environment

17. Specific policies and legislation that promote a human rights-based approach should be developed. Where these exist, they should be revised to ensure that approaches for the prevention of discrimination and for increasing access to services are incorporated. Specific issues that need to be addressed include stigmatization of people living with HIV; discrimination against them in employment, marriage, founding a family, access to health care and medicines; youth testing and counseling; sexual violence and deliberate transmission of HIV. Policies should take into account age and gender issues (including rape) and exposure of under-age persons to alcohol and drugs consumption and other risky behaviour.

18. All channels of communication should be drawn upon to ensure that the general public and specific target groups are adequately informed about existing policies and legislation related to HIV/AIDS. Emphasis should be put on channels that facilitate interactive discussions with communities, families and individuals.

Expanding and intensifying effective HIV prevention interventions

19. Prevention efforts and interventions that work best in the Region should be identified and tailored to specific cultural and social circumstances prevailing locally.

20. Behaviour change communication interventions should be strengthened using all opportunities of contact with various groups. These services should be youth-friendly and should also target commercial sex workers. Operational research should also be strengthened to guide behaviour change communication programmes, particularly among the most vulnerable populations.

21. It is necessary to strengthen management of sexually-transmitted infections (STIs) by building the capacity of health-care workers to provide quality syndromic management, ensure availability of drugs, improve tracing and treatment of partners, promote correct and consistent use of condoms, and strengthen STI surveillance systems.

22. Routine testing at tuberculosis (TB) clinics, STI units, and other inpatient and outpatient departments can help to scale up HIV testing and counselling services. VCT services can be expanded to reach peripheral and remote health centres where there is also the possibility of using mobile and satellite units. The use of simple techniques such as rapid testing and working with lay providers for counselling and testing services has also proved successful.

23. Implementing innovative strategies and using all points of contact with pregnant women can expand coverage and uptake of PMTCT interventions. These include universal testing and counselling for pregnant mothers with an "opt out" option, rapid HIV testing during labour, routine offer of family planning services to women who have been through antenatal care and postnatal services and who want to avoid future pregnancies, and routine rapid HIV testing for newborns of untested high-risk mothers. Infant feeding policies and support mechanisms should be put in place to assist mothers in reducing the risk of HIV transmission through breastfeeding.

24. Development and implementation of appropriate national blood transfusion policies and expansion of services to the peripheral levels can strengthen blood and blood products safety programmes.

25. Infection prevention and control measures can be strengthened by ensuring development and implementation of policy guidelines and workplans on injection safety, post-exposure prophylaxis (to include services for the sexually-abused and health-care providers), health care waste management, timely availability of safety equipment and supplies, and treatment.

26. Use of condoms, including female condoms, by both men and women should be promoted throughout the society. There should be a special focus on STI clients, TB patients, commercial sex workers and their clients, PLWHA and their partners.

Linking HIV/AIDS prevention, treatment, care and support in an "essential package"

27. A Technical Working Group should be set up to define the "essential package" and develop operational mechanisms for all levels. The Technical Working Group should include as many stakeholders as possible and adopt a participatory approach to achieving national consensus on the essential package.

28. In order to effectively contribute to the implementation of interventions, the essential package for HIV/AIDS prevention, treatment, care and support should be defined as encompassing public health, education, legal and social service issues. The approach should be decentralized and integrated with emphasis on delegation of authority, collaborative activities between programmes, task shifts and capacity building at the district and community levels.

29. Existing technical policies and guidelines for the delivery of prevention, treatment, care and support policies will have to be revised to embrace the essential package. The revised technical

policies and guidelines should reflect new approaches for increasing access to services, including task shifts.

Increasing access by scaling up implementation and adopting a national simplified public health approach

30. It will be necessary to develop or update national plans for HIV/AIDS prevention, treatment and care with a view to universal access. The development of the plan should be based on consensus among all key stakeholders. The plan should quantify resource gaps; build on existing programmes, resources and capacities; and define the role of various stakeholders.

31. Simplified and evidence-based methods should be adopted for the implementation of interventions. This ensures that first-line health workers are able to use these approaches with Integrated Management of Childhood Illness (IMCI), Integrated Management of Adolescent and Adult Illness (IMAI), TB, malaria and PMTCT activities. For their part, heath-care workers should integrate such interventions with the interim WHO clinical staging of HIV/AIDS and HIV/AIDS case definition for surveillance,[14] HIV testing and counselling guidelines, simple and standardized antiretroviral therapy regimens and enrolment guidelines, monitoring of patients who are on treatment, prevention in HIV-positive and discordant couples, and syndromic management of STIs.

32. There is need to strengthen community participation as part of scaling up HIV interventions. Every effort must be made to encourage communities to talk about HIV/AIDS, its effect on their lives, and actions to be taken to deal with the epidemic. They should also be engaged in activities aimed at positive behaviour change, improving knowledge about treatment, and creating awareness regarding testing and counselling. Associations of PLWHA must be supported to play a leading role in facilitating community participation in prevention, treatment adherence and reduction of HIV-related stigma.

Strengthening health systems to meet increasing demand

33. The leadership role of the Ministry of Health (MOH) should be strengthened to include coordination, regulation, implementation, monitoring and evaluation of activities. In accordance with the “Three Ones” principle, appropriate mechanisms for coordination of the activities of relevant MOH departments and other stakeholders need to be defined, including the specific and complementary roles of the MOH, national AIDS councils or commissions, other sectors of government, and the private and corporate sectors.

34. Revitalization of district structures and capacities is necessary because HIV prevention and care programmes are mainly implemented at district level. District health teams need to be strengthened in terms of staffing and skills to effectively plan, implement and monitor interventions. Linkages with community-based organizations and civil society groups should be established at district level.

35. It is imperative that knowledge and skills for key interventions are integrated into pre-service and in-service training curricula. Innovative ways for expanding training as well as retaining and motivating staff, especially at peripheral levels, need to be explored.

[14] Interim WHO clinical staging of HIV/AIDS case definition for surveillance http:/www.who.int/hiv/pub/guidelines/casedefinitions/en (last accessed 12-04-2006).

36. To ensure availability of quality diagnostics, medicines and commodities, countries will need to improve their procurement and supply management systems, including estimation and projection of requirements, use of information on best prices and suppliers. Quality control systems for generic and proprietary diagnostics and medicines should be strengthened.

37. The laboratory plays a critical role in HIV/AIDS prevention and control. Countries should ensure that the needs for strengthening and decentralizing laboratory services are adequately addressed in the comprehensive implementation plan.

38. Strategic information collection and management are important to guide the implementation of scaling up HIV prevention, treatment, care and support programmes. Countries must develop systems for tracking progress of the epidemic, implementation and outcomes of interventions, and HIV drug resistance.

Increasing and sustaining financial resources

39. Countries should continue to strive to achieve the Abuja Declaration target of allocating 15% of their budgets to the health sector. Additional resources need to be mobilized from donors and development partners for overall health system strengthening, including human resources for health and improvement of infrastructure. Innovative methods of mobilizing funds from the private, corporate sector and communities should be pursued. HIV/AIDS interventions should be integrated with the national agendas for development and poverty alleviation. Resource mobilization should consider appropriate utilization and reallocation of existing resources while strengthening the country's capacity to absorb additional resources.

40. Member States should increase their efforts to put in place sustainable pro-poor financing mechanisms for the provision of services.[15] Countries should strengthen mechanisms for reporting and tracking funds in order to ensure accountability and transparency. Particular attention should be given to mechanisms for rapid disbursement of funding to peripheral levels to improve access to services.

41. Existing partnerships should be strengthened and nurtured through the involvement of key stakeholders, including PLWHA, in programming as well as regular sharing of information on progress. The United Nations Theme Group, the International Donor Groups, Country Coordinating Mechanisms, the Technical Working Group on HIV/AIDS as well as other partnership forums should be utilized. The momentum generated by The 3 by 5 Initiative should be used to scale up HIV prevention interventions.

ROLES AND RESPONSIBILITIES

Countries

42. Governments should ensure stewardship and leadership as well as forge partnerships with civil society and PLWHA for developing plans and mobilizing both internal and external resources for accelerating HIV/AIDS prevention, treatment, care and support interventions. Governments should also ensure effective coordination of interventions; the health sector should provide technical guidance for the implementation of this health sector HIV prevention strategy, within the framework of intersectoral collaboration.

[15] WHO, The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care, Geneva, World Health Organization, discussion paper, December 2005.

43. Countries should be responsible for implementing planned activities, monitoring and evaluating programmes, and coordinating all partners.

World Health Organization and other partners

44. WHO will provide technical leadership and normative guidance for developing plans of action, implementing programmes, monitoring and evaluation.

45. WHO and other partners will provide support to countries in resource mobilization, planning (including estimation of costs) and strengthening government capacity to coordinate the activities within the framework of the "Three Ones" principle.

MONITORING AND EVALUATION

46. Global consensus has been reached on a monitoring and evaluation framework for HIV/AIDS.[16] The indicators and approaches in the framework and other agreed interagency indicators will guide monitoring and evaluation of this regional strategy. Intensified efforts will be made to monitor the incidence of HIV infection in order to more effectively assess the impact of prevention interventions. Monitoring of progress in the implementation of the strategy will be carried out every two years and reported to the Regional Committee.

CONCLUSION

47. The impact of the HIV/AIDS epidemic has seriously undermined progress made in human development in the past decades. It has contributed to high morbidity and mortality, resulting in reduction of life expectancy, with grave social and economic consequences. Despite the efforts undertaken at national, regional and international levels, HIV incidence remains very high, indicating that HIV prevention efforts have not been adequate. It is imperative to renew and accelerate HIV prevention, linking it with treatment, care and support, and adopting clear and comprehensive strategies and actions as set out in this document.

48. The Regional Committee is requested to review and adopt this proposed strategy along with the attached resolution.

[16] Monitoring and evaluation toolkit HIV/AIDS, TB and malaria http://www.who.int/hiv/pub/epidemiology/en/me toolkit en.pdf (last accessed 12-04-2006).