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ACCELERATION OF HIV PREVENTION IN THE WHO AFRICAN REGION: PROGRESS REPORT

Information Document

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BACKGROUND

1. In 2005, ministers of health adopted resolution AFR/RC55/R6 on acceleration of HIV prevention in the African Region, calling upon Member States to accelerate HIV prevention and declaring 2006 the Year of Acceleration of HIV Prevention in the African Region. The resolution also requested the Regional Director to develop a strategy for acceleration of HIV prevention, provide the necessary technical support to countries, help mobilize additional resources and monitor implementation.

2. The strategy document, "HIV prevention in the African Region: strategy for acceleration and renewal," was developed and subsequently adopted at the fifty-sixth session of the Regional Committee. The strategy includes targets[1] to be met by 2010, particularly in areas of HIV testing and counselling (HTC); blood safety; prevention of mother-to-child transmission (PMTCT) of HIV; prevention and control of sexually-transmitted infections (STIs); condom use; and access to comprehensive prevention, treatment and care.

3. This report complements the previous one submitted at the fifty-eighth session of the Regional Committee. It provides updated information on key health sector HIV prevention indicators defined in the strategy, and it highlights issues that should be taken into consideration for moving the HIV prevention agenda forward in the health sector.

PROGRESS MADE

4. Between 2007 and mid 2008, all districts reported at least one HTC facility, and the proportion of health facilities providing HTC services increased from 17% to 22%.[2] Innovative approaches to scale up HTC include mobile and home-based HTC and HIV testing weeks. However, in sub-Saharan Africa, on average, only 16.5% of people living with HIV are aware of their HIV status.[3]

5. In 2007, 40 countries reported that 100% of the blood used for transfusion was screened for HIV; this compared to 98% in 2004.[4] Eleven countries[5] are implementing specific programmes[6] to strengthen infection prevention and control; however, reports indicate that 50% of medical injections administered in developing countries were given with re-used, non-sterilized equipment.[7]

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[1] HTC: All districts to provide HIC testing and counselling services; 100% safe blood and blood products ensured; at least 80% of pregnant women attending antenatal care will access PMTCT services; at least 80% of patients with sexually-transmitted infections will access comprehensive STI management; at least 80% of people living with HIV/AIDS will have access to comprehensive prevention, treatment and care services; condom use will reach at least 60% in high-risk sexual encounters.

[2] WHO, World Health Organization, Regional Office for Africa database, 2008.

[3] WHO, *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector*. Progress report 2008, Geneva, World Health Organization, 2008.

[4] Tapko JB, Sam O, Diarra-Nama AJ, *Status of blood safety in the WHO African Region: report of the 2004 survey*, Brazzaville, World Health Organization, Regional Office for Africa, 2008.

[5] Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Nigeria, Rwanda, South Africa, Tanzania, Uganda and Zambia.

[6] PEPFAR projects being implemented in countries with support from John Snow Incorporated in close collaboration with the WHO Regional Office for Africa.

[7] WHO, Injection Safety Programme, *www.who.int/injection_safety/en/, accessed* 29 September, 2008.

6. Uptake of PMTCT increased from 10% in 2005 to 34% in 2007, ranging from 11% in western and central Africa to 43% in eastern and southern Africa.[8] Botswana has reached the 80% target and five other countries[9] are moving towards the target. In addition, available data from 19 countries[10] in the Region indicate that by mid 2008, 13 174 antenatal care facilities were providing PMTCT, as compared to 10 600 in 2007. This represents an increase from 31% to 40% in only six months.

7. STIs remain a burden in the Region, and *Herpes simplex* virus type-2 has become the leading cause of genital ulcer disease. Updates of treatment protocols were reported from 31 countries,[11] and integration of comprehensive STI case management into training and reproductive health programmes is under way.

8. By June 2008, over 2.6 million patients were on antiretroviral therapy, representing a 24% increase in just six months. Approximately 22% of tuberculosis patients were screened for HIV and 89% of tuberculosis patients with HIV were on cotrimoxazole preventive therapy, while 37% of them were on antiretroviral therapy.[12]

9. Demographic and Health Surveys carried out between 2005 and 2008 indicate that condom use for last high-risk sexual encounter among people aged 15–49 years ranged from 26% to 71% for males and 14% to 47% for females, with a median of 45% for males and 26% for females. Condom use among 15–24-year-olds engaging in high-risk sex increased in 10 out of 14 countries with trend data.[13]

10. Other notable developments include initiatives to scale up male circumcision for HIV prevention in 12 countries,[14] analysis of modes of epidemic transmissions and responses for strengthening HIV prevention in 14 countries,[15] and implementation of school-based HIV prevention through training of teachers in 25 countries.[16]

11. HIV prevention is firmly on the agenda of Member States and development partners. Despite progress made, prevention programmes have not yet adequately reached the most-at-risk populations, including young females, sex workers, injecting drug users, prisoners and men who have sex with men. Challenges include weak health systems to support scaling up of effective HIV prevention interventions, addressing multiple and concurrent sexual partnerships, translating research findings on male circumcision into programme implementation, and limited use of available data.

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[8] WHO, *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector*. Progress report 2008, Geneva, World Health Organization, 2008.

[9] Kenya, Namibia, Rwanda, South Africa and Swaziland.

[10] Benin, Botswana, Burkina Faso, Cameroon, Central African Republic, Democratic Republic of Congo, Ethiopia, Gambia, Guinea-Bissau, Liberia, Malawi, Mali, Namibia, Rwanda, Sierra Leone, Tanzania, Togo, Uganda and Zimbabwe.

[11] Algeria, Botswana, Burkina Faso, Cameroon, Cape Verde, Central African Republic, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Ghana, Guinea, Guinea-Bissau, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Zambia and Zimbabwe.

[12] WHO, *Status report on tuberculosis in Africa*, Brazzaville World Health Organization, Regional Office for Africa, 2008; WHO, *Global tuberculosis control: surveillance, planning, financing*, Geneva, World Health Organization, 2008.

[13] Benin, Burkina Faso, Cameroon, Ethiopia, Guinea, Kenya, Malawi, Mali, Tanzania and Zambia.

[14] Botswana, Kenya, Ghana, Lesotho, Mozambique, Namibia, Nigeria, Rwanda, Swaziland, Tanzania, Uganda and Zimbabwe.

[15] Benin, Burkina Faso, Ghana, Guinea, Kenya, Lesotho, Liberia, Mali, Mozambique, Niger, Nigeria, Senegal, Togo and Uganda.

[16] Benin, Botswana, Burkina Faso, Burundi, Cote d'Ivoire, Ethiopia, Gabon, Ghana, Guinea, Kenya, Lesotho, Liberia, Malawi, Mali, Namibia, Niger, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

NEXT STEPS

12. Scaling up of HIV testing and counselling should be accelerated, using all possible entry points, and coverage of antenatal care should be increased for greater PMTCT uptake. Effective scaling up of HIV prevention interventions also requires strengthened health systems, effective community participation and strategic partnerships.

13. Multisectoral collaboration is needed to address sexual transmission of HIV. Greater attention should be given to targeting those who are most-at-risk, controlling STIs, strengthening the control of HIV-TB dual infection, and intensifying prevention programmes that target people living with HIV/AIDS. Recent evidence[17] calls for addressing multiple concurrent sexual partnerships and scaling up male circumcision services, particularly in high prevalence countries.

14. There is need to strengthen strategic information to better assess the driving factors of the epidemics and the impact of interventions, ensure effective monitoring and better understand the impeding factors.

[17] *www.the lancet.com*, Volume 372, August 9, 2008.