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Annex I

PROGRESS REPORT ON THE IMPLEMENTATION OF THE COMMITMENTS OF THE MAY 2006 ABUJA SPECIAL SUMMIT ON HIV/AIDS, TUBERCULOSIS AND MALARIA (ATM)

ANNEX I

STATUS REPORT ON HIV/AIDS IN AFRICA

TABLE OF CONTENTS

EXECUTIVE SUMMARY

At their May 2006 Special Summit, AU Heads of State and Government recommitted their countries to accelerate the implementation of the 2000 and 2001 Abuja Declarations and Plans of Action on HIV/AIDS, TB and Malaria. Their deliberations focused on accelerating action towards universal access to HIV/AIDS, TB and Malaria Services by 2010. It is required that regular progress reports be submitted to the AU Organs and the UN General Assembly on the status of implementation of the commitments.

The report covers the main priority interventions undertaken by Member States, such as program policy and management, advocacy, HIV testing and counseling (HTC), prevention of mother-to-child transmission (PMTCT), and access to anti-retroviral therapy (ART).

The main source of data for this report (HIV section) is country reports based on a WHO framework on monitoring the health sector response towards Universal Access for HIV prevention, care, and treatment, as well as from UNAIDS and other reports. The reports also draw from progress report on the implementation of the Political Declaration of the 2006 UN General Assembly Special Session and High Level Meeting on HIV/AIDS.

Findings:

The following findings are recorded for the period under review:

i. In recent years, bilateral and multilateral organizations have increased their HIV support. The Global Fund to Fight AIDS, Tuberculosis and Malaria currently provides 20% of all funding for HIV/AIDS. The success rate of Round 7 proposals for HIV about 60% (10 out of 17).

ii. Of the 35 countries that responded, 31 (90%), 28 (80%), and 21 (60%) reported having policy or guidelines on ART, PMTCT, and HTC—respectively.

iii. Almost two-thirds (63%) of the countries reported setting national targets for HTC, PMTCT, and ART. Over three quarters (77%), have set national PMTCT targets, while 70% (24 countries) have set for HTC and ART

iv. Of the 35 countries that reported, 18 (46%) have a policy that allows lower level health workers—once trained—to provide second-level services, such as managing patients with HIV and ADIS

v. Among 35 countries in the Africa region, one in every five facilities provide HTC services—ranging from less than 1% in Liberia to 100% in Botswana

vi. In 2007, over 470,000 HIV positive pregnant women reportedly received ARVs for PMTCT purposes —over 50% increase from 2006 figure of slightly over 300,000.

vii. In 2007, over 2.1 million people received ART in countries of this region. This represents a 60% increase in just one year—as 1.3 million people received ART in 2006.

viii. Among the 35 countries that reported, 7 (20%) experienced stock outs of ARVs in part or all facilities that provide ART.

ix. Of the 35 countries that submitted the Universal Access (UA) reporting form, 80% implement ANC surveillance by using the WHO-recommended HIV 2nd generation surveillance protocol.

In conclusion, countries in Africa took giant steps towards Universal Access for HIV prevention, care, and treatment. Among documented achievements include: increased access to ART, PMTCT and HTC.

As concerns African countries under the WHO Eastern Mediterranean Region, the overall numbers of reported HIV cases remain small except in (Sudan), although they are slowly increasing partially due to expanding testing efforts. Access to prevention, treatment, care and support tends to be more easily available except in countries under special circumstances such as conflicts.

Way Forward:

As a way forward, the following recommendations are made:

- HTC coverage is relatively low—compared to ART and PMTCT. Provider-initiated testing and counseling (PITC) should be expanded to all public health facilities of every country
- Countries should not lose the momentum of prevention, PMTCT and ART scale up and have to continue or even increase the level of efforts till Universal Access targets are fully achieved.
- Infant diagnosis and care & treatment for infected children should be expanded.
- Investment and strengthening of strategic information should be undertaken, particularly in methods of understanding the dynamics of specific country epidemics and its drivers

- Even countries with low prevalence rates or where success has been reported, should avoid complacency.
- Member States are urged to monitor implementation and submit reports regularly.
- Partners at national, regional and international level should sustain their technical and financial support as well as advocacy

1. BACKGROUND

In April 2001, African leaders met in Abuja to address the challenged posed by HIV/AIDS, Tuberculosis, and other related infectious diseases. The primary objective of the declaration was to arrest and reverse the frightening rate at which these priority diseases are depleting the gains made in combating communicable diseases in the continent. They adopted the related Abuja Declaration and Framework for Action, and declared HIV/AIDS an emergency and a threat to security. The Abuja Declaration and Framework for Action was Africa's contribution towards the 2001 United Nations General Assembly Special Session (UNGASS) on HIV/AIDS.

In May 2006, the Heads of State and Government again held a Special Summit on HIV/AIDS, TB and malaria to review the status of implementation of their previous commitments on these diseases. They reviewed the continental status report on the implementation of the Abuja Plans of Action and adopted commitments to promote Universal Access to HIV/AIDS, TB and Malaria Services by 2010. The African leaders highlighted a Framework for Action, which requested for implementation and reporting on the following 12 priority areas:

- Leadership
- Resource Mobilization
- Partnership
- Enabling Environment and Protection of Human Rights
- Information, Education and Communication
- Poverty, Health and Development
- Strengthening Health Systems
- Prevention
- Access to Care and Support
- Access to Affordable Drugs and Technologies
- Research and Development
- Monitoring and Evaluation

The Leaders also requested for progress reports on the 2006 commitments in 2008 and 2010.

2. INTRODUCTION

As of December 2007, UNAIDS and WHO estimated over 33 million people were living with HIV worldwide—of which about two-thirds live in African countries south of the Sahara. In addition, an estimated 2.5 million people were newly infected in 2007, and 2.1 million died of AIDS.[1] The numbers for northern African countries are still low although slowly increasing.

In 2001, the United Nations convened a special session on HIV/AIDS (UNGASS) and has agreed to a set of global targets in response to the growing public health threat against all nations, particularly in middle and low income countries[2]. In 2006, at the second United Nations General Assembly High Level Meeting on HIV/AIDS, the world leaders committed their nations to work towards the goal of "universal access" for comprehensive HIV prevention, care, treatment, and support" by 2010."[3] This commitment, and others like the Abuja Declarations, complements the health-related UN Millennium Development Goals, which establish targets on reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other major diseases by 2015[4].

Although Africa especially the countries south of the Sahara seems to be lagging behind on most of the global targets, the increased global and national commitments, as well as financial investments towards combating HIV and AIDS, have produced tangible progress that can motivate politicians and public health workers to accelerate their efforts towards above targets and goals. A rapidly growing number of people have access to HIV prevention, care and other interventions. Available data indicate that in Africa, access to HIV testing and Counseling (HTC), Prevention of Mother-To-Child-Transmission (PMTCT) and antiretroviral therapy (ART) is increasing substantially. Furthermore, there is evidence that prevention programs are paying off dividends since behavior change and declining HIV prevalence in some high-burden countries have been documented in recent years[5].

2.1 PURPOSE

The main purpose of this progress report is to give account of progress made by Member States since 2006 towards Universal Access for HIV prevention, care, and treatment. The report covers the main priority interventions, such as program policy and management, HIV testing and counseling (HTC), prevention

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[1] 2007 AIDS Epidemic Update. Geneva, UNAIDS/WHO, December 2007.
[2] United Nations General Assembly Special Session on HIV/AIDS, 25-27 June 2001. Declaration of Commitment on HIV/AIDS.
[3] United Nations General Assembly Sixtieth Session. Political Declaration on HIV/AIDS. (UN General Assembly document 60/262). 15 June 2006.
[4] http://www.un.org/millenniumgoals/ accessed on 25 March 2008.
[5] 2007 AIDS Epidemic Update. Geneva, UNAIDS/WHO, December 2007.

of mother-to-child transmission (PMTCT), and access to anti-retroviral therapy (ART).

2.2 METHODS

The main source of data for this report (HIV section) is country reports based on the WHO and UNAIDS frameworks on monitoring the health sector response towards Universal Access for HIV prevention, care, and treatment. Of the 46 countries in the WHO African Region, 35 have submitted a standard reporting form for monitoring the health sector response. These data will be validated and reconciled with other global reporting mechanisms, such as UNGASS. Additional source of information is the PMTCT card (UNICEF/IATT)

The WHO reporting form is designed to collect 27 indicators which cover availability, coverage and outcome/impact, of priority HIV interventions. Since a global report on health sector response will be launched during the World Health Assembly in May 2008, this progress report will not discuss all indicators but rather highlights important milestones since May 2006 on priority interventions in HIV and AIDS.

3. FINDINGS

3.1 Leadership, Partnerships, and Resource Mobilization

In response to adopted Resolution AFR/RC55/R6, under the auspices of the African Union, the member states launched the campaign to accelerate the HIV prevention strategies and interventions in Addis Ababa in April 2006. Consequently, countries responded by putting in place a number of initiatives, based on their local context. This initiative catalyzed important HIV prevention achievements in many countries in the region. Interventions that received substantial boost from this initiative are HTC and PMTCT.

In recent years, multilateral organizations have increased their HIV support. The Global Fund to Fight AIDS, Tuberculosis and Malaria currently provides 20% of all funding for HIV/AIDS. The success rate of Round 7 proposals for HIV in this region was about 60% (10 out of 17)—which is considered to be the best year in this region. It has continued to expand grants allocated for HIV prevention, care and treatment programmes in recent years, and was successful in securing commitments for increased investment from donor countries in 2007

Through a CIDA grant of about 30 million (Canadian $), WHO is supporting 10 high HIV prevalence countries in the region to scale up PMTCT services to selected districts. This grant is intended to supplement the ongoing efforts to improve access of PMTCT services within the context of the broader family health domain.

Besides the global partnerships, such as GFATM and PEPFAR, several smaller partnerships are mushrooming at country levels. A good example of this is the UNITAID's partnership with African countries to contribute to scaling up access to treatment for HIV/AIDS, malaria and tuberculosis by leveraging quality drug and diagnostic price reductions and accelerating the pace at which these are made available to patients in need of them. With UNITAID partnership, partner countries are receiving price reductions of up to 40% for 1st and 2nd line ARVs and diagnostic facilities[6].

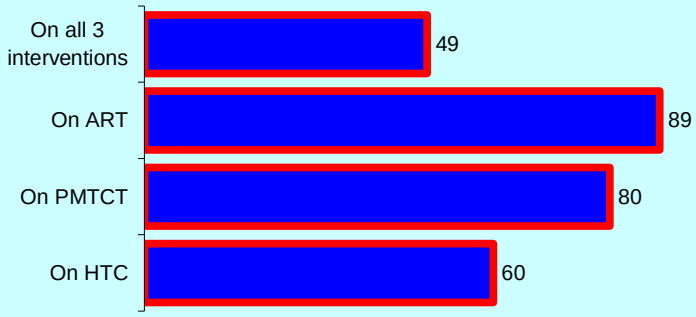
The United States remains the largest bilateral donor, contributing more than half of total bilateral aid to HIV since 2006—mainly through the US President's Emergency Plan for AIDS Relief (PEPFAR). Early this year, the US Congress has debated and passed the reauthorization, with possibility to more than double the current level of funding over the next five years[7]. Other major bilateral funding sources include the United Kingdom, whose share in the total represents 12%; and the Netherlands, Germany, France, Sweden and Canada, whose contributions together represent another 20% of the total contribution from OECD DAC members. As at the end of 2006, a total of US$5.56 million was committed, of which US$3.9 million was disbursed (bi-laterals accounted for 76%, while GFTATM 24.2% of these disbursements)[8]

3.2 STRENGTHENING HEALTH SYSTEMS

As the overwhelming majority of the HIV and AIDS services are planned and executed within the health sector, the health systems of low and middle income countries are outstretched and are unable to cope with the additional burden—unless additional resources are allocated to them. With HIV and AIDS care and treatment services comes a huge price tag in strengthening capacity for new and expensive diagnostic tools as well as treatment regimens.

Major global stakeholders are beginning to realize the importance of health systems strengthening within the context of the Universal Access approach. For this reason, major global funding mechanisms for HIV/AIDS, such as GFATM and PEPFAR, are encouraging

Figure 3.1: % of countries reported having policy/guidelines on HTC, PMTCT and ART, in WHO African Region, 2007



[6] About UNITAID. http://www.unitaid.eu/en/UNITAID-budget.html
[7] The Global AIDS Fight. Editorial. *The New York Times*. February 29, 2008.
[8] Financial resources required to achieve universal access to HIV prevention, treatment, care and support. UNAIDS, Geneva: pg. 3 Additional information can be found at: *http:data.unaids.org/pub/presentation/2007/20070605 unaids kff ppoint en.pdf*

low/middle income countries to place health systems strengthening on the top of their health agenda.

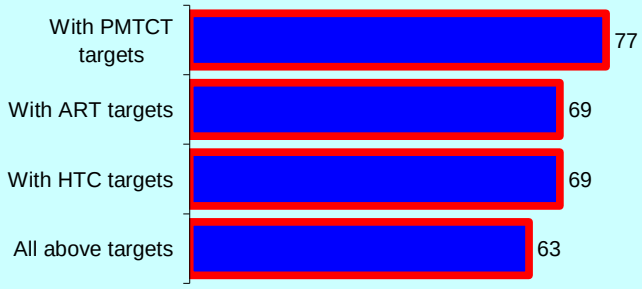
3.2.1 National Policy/Guidelines for Priority HIV Interventions

Access to HIV interventions first and foremost requires availability of clear policies to guide which approaches to take and how to deliver the services. All countries are usually expected to have adequate policy document, as well as appropriate guidelines, for health workers to use during service delivery. Of the 35 countries that responded, 31 (90%), 28 (80%), and 21 (60%) reported having policy or guidelines on ART, PMTCT, and HTC—respectively. Only 17 countries—almost half—reported having such documents for all three interventions (Figure 3.1)

3.2.2 Setting National Targets for Universal Access

There is no global target for Universal Access in HIV prevention, care, and treatment. Each country, based on its resources and work environment, is expected to set its own targets toward the Universal Access for HIV prevention, care and treatment. As countries develop their national strategic plans (NSPs), the expectation is for them to develop national targets for priority HIV interventions.

Figure 3.2: % of countries that reported having national targets for HTC, PMTCT, and ART, WHO African Region, 2007
n=35



Almost two-thirds (63%) of the countries reported setting national targets for HTC, PMTCT, and ART. Over three quarters (77%), have set national PMTCT targets, while 70% (24 countries) have set for HTC and ART (Figure 3.2).
Meanwhile in Libya and Tunisia the target is 34% of infected men and women to receive ART. In other countries i.e. Egypt, Somalia and Sudan, the focus is on pregnant women and other infected women- the target ranges from 1.0% in Sudan to 7.3% in Egypt.

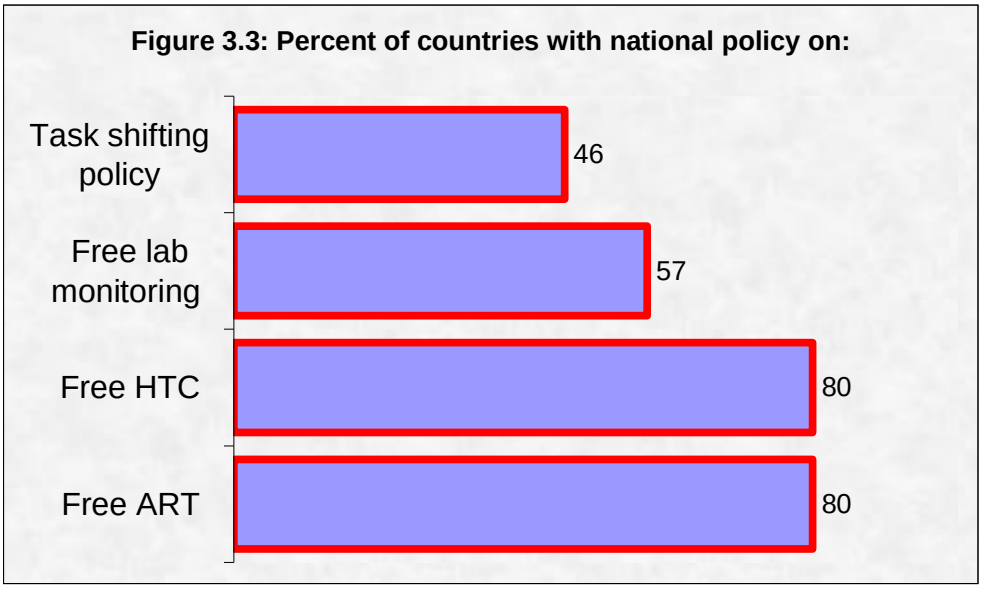
3.2.3 National Policy for Task Shifting and Free HIV Care and Treatment Services

Human resource constraints represent the main health systems challenge facing most of the countries in the region to reach the global and national targets on

Universal Access for HIV prevention, care, and treatment. In 2007, WHO, in collaboration with health development partners and national authorities, developed a plan to tackle the health workforce problems through a new initiative, which commonly known as "Treat Train Retain" or TTR. The TTR is based on three principles: I) Treat health workers by providing comprehensive care and treatment packages; II) Train, including task shifting to lower level health workers; III) Retain, through improving work environment, financial and non-financial incentives to motivate health workers to remain in country and serve those who need care most. Task shifting happens when lower level health workers are trained and given tasks, which are normally reserved for highly trained workers, such as doctors.

Although TTR is a new concept, some of its elements, such as task shifting, are already operational in a number of countries in the region. Of the 35 countries that reported, 18 (46%) have a policy that allows lower level health workers—once trained—to provide second-level services, such as managing patients with HIV and AIDS (Figure 3.3).

Figure 3.3: Percent of countries with national policy on:



Although the cost of HIV care and treatment services is gradually becoming affordable, these are still beyond the means for millions of poor people infected or affected by the epidemic. As part of the Abuja and UNGASS commitments, African leaders resolved to make these life-saving interventions free for those who cannot afford.

About one third of reporting countries (57%) indicated to have a national policy which offers free laboratory monitoring services for patients on ART. Such services include CD4 count or viral loads, which otherwise cost more than the treatment.

An equal number of countries (28) reported having a policy of free HIV testing and counseling as well as ART services for their citizens. In other countries such as Sudan, a high rate of turn-over of staff limits the ability to meet the long-term requirements of policy response. In Tunisia the emphasis is on information, education and communication as a policy strategy. Whereas in Egypt, HIV-related activities have been mainstreamed into and initiated within programmes addressing people most likely to be exposed to HIV. In Somalia, the continuing humanitarian crisis, conflict and emergencies directly affect sustainability of any policy for an effective long-term response.

Such leadership qualities are likely to foster a favorable environment for the expansion of services all the way to Universal Access.

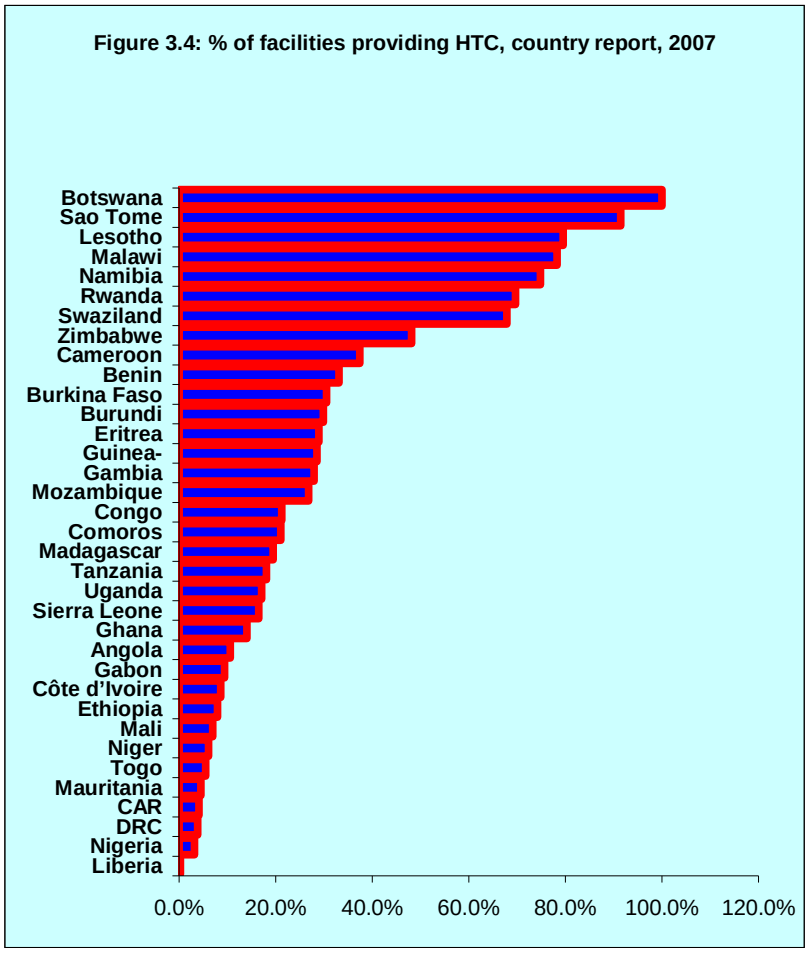
3.3 SCALING UP PRIORITY SERVICES

WHO provides guidance to countries to develop comprehensive packages which are tailored to local needs, including on how the different interventions can be integrated into various service delivery models. The package consists of an array of services that are usually facility based—and sometimes community-based—from HTC to treatment of opportunistic infections to infection control. However, this report covers the three main interventions, which are: HIV testing and counseling, Prevention of Mother to Child Transmission (PMTCT), and anti-retroviral therapy (ART.

3.3.1 HIV TESTING AND COUNSELING (HTC)

Scaling up access to HIV testing and counseling is the gateway to prevention, care, and treatment services. For HIV-infected individuals, HIV testing is the first step towards early care and treatment services. On the other hand, for those who are not infected with HIV, it provides an opportunity to have appropriate tools and information to reduce the risk of HIV transmission. HIV

Figure 3.4: % of facilities providing HTC, country report, 2007



testing and counseling is therefore very critical to the achievement of universal access to HIV prevention, care and treatment.

Countries are implementing various models of HTC, from the traditional voluntary counseling and testing (VCT) to the new concept of provider initiated HIV testing and counseling.

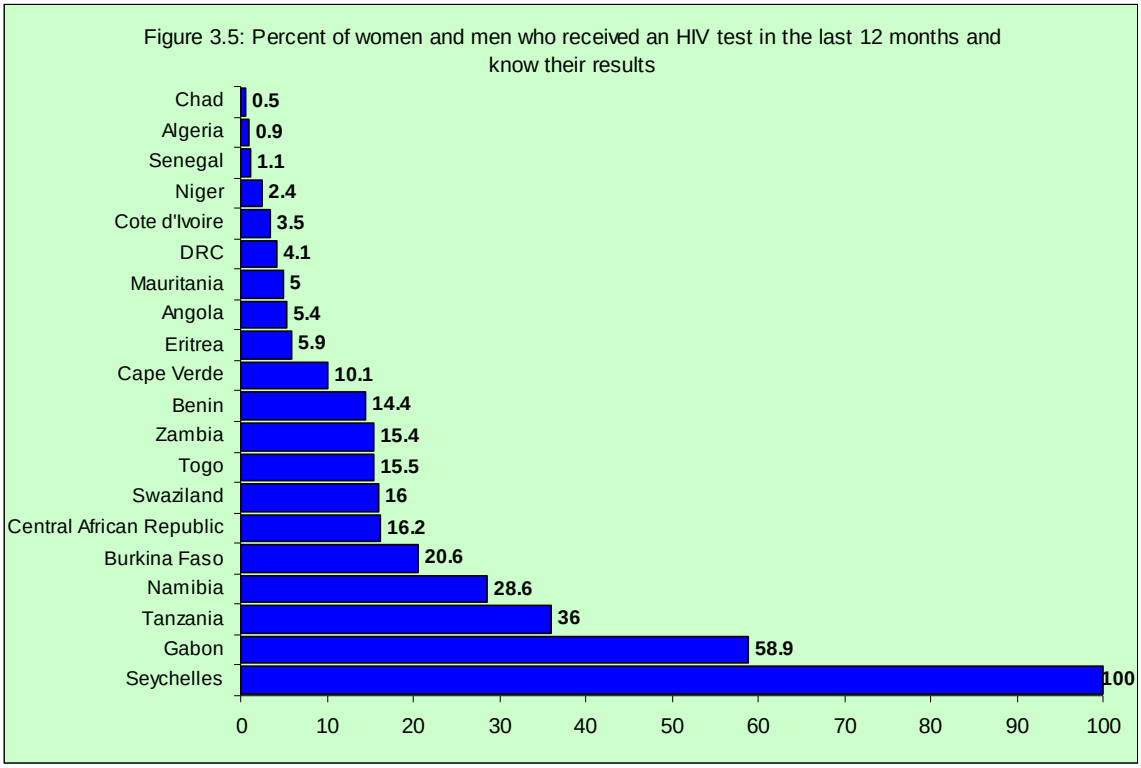
In 2007, WHO and UNAIDS issued new guidance on HIV testing and counseling in health facilities to increase uptake of HIV testing and counseling and improve access to health services for people living with HIV[9].

Among 35 countries in the WHO Africa region, one in every five facilities provide HTC services—ranging from less than 1% in Liberia to 100% in Botswana (Figure 3.4, adjusted the scale to reflect a maximum of a 100%). In 2007, the total number of health facilities that provided HTC services ranged 1 in Liberia to 1,107 facilities in Cameroon. Tanzania reported second in the term of available HTC facilities with 1,035. The median number of the HTC facilities per country is 164. In the EMRO region, Somalia is scaling up integrated prevention, treatment, care and support aligning ART, voluntary counseling and testing with the support of the Global Fund. In Sudan there is very limited access to prevention, testing, treatment, care and support, especially in rural areas.

A more compelling statistic is the actual uptake of VCT (ie. percentage of people who take an HIV test and receive the results compared to the targets of respective countries – where these are available).

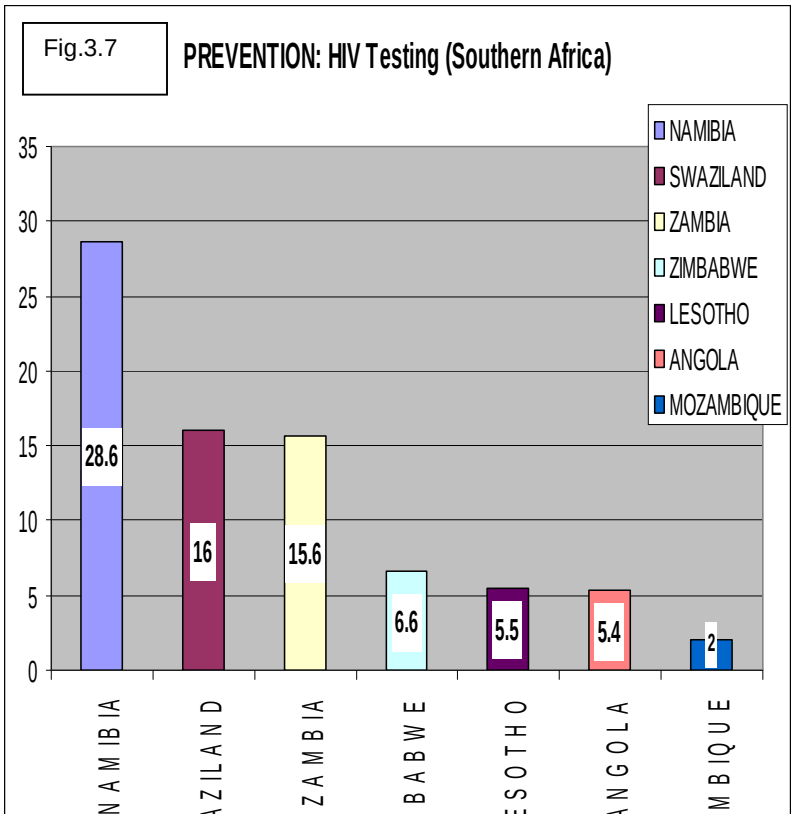
Fig 3.5 shows the percent of men and women who received an HIV test in the last 12 months and know their results in selected countries. The figure shows the variability in progress in the countries. HTC coverage remains low in Africa.

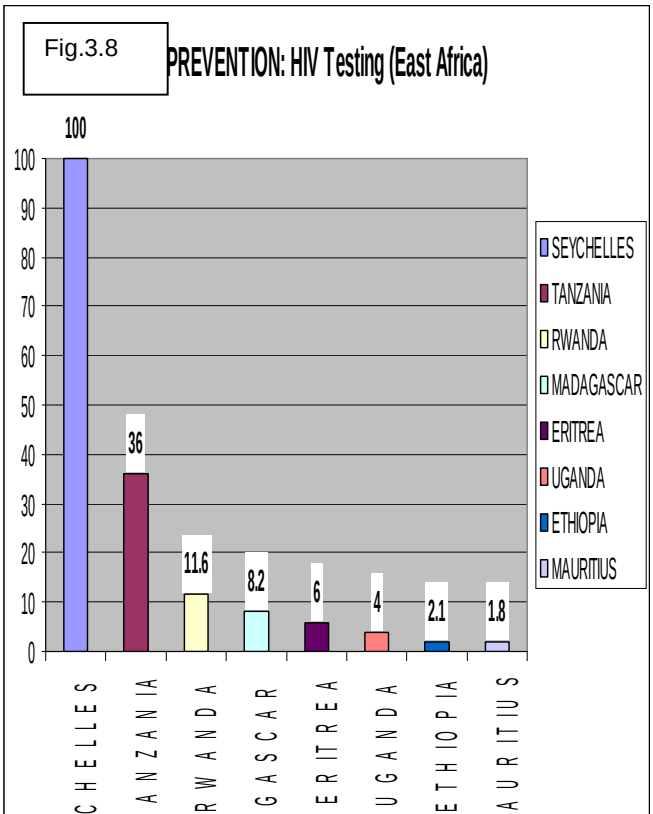
[9] Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities. WHO, UNAIDS. Geneva, 2007.



Source: 2007 UNGASS Country Reports

The figures 3.7 and 3.8 below for Southern and East Africa show percent of women and men who received an HIV test in the last 12 months and know their results.





Source: 2007 UNGASS reports or go to:
http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2007CountryProgressAllCountries.asp

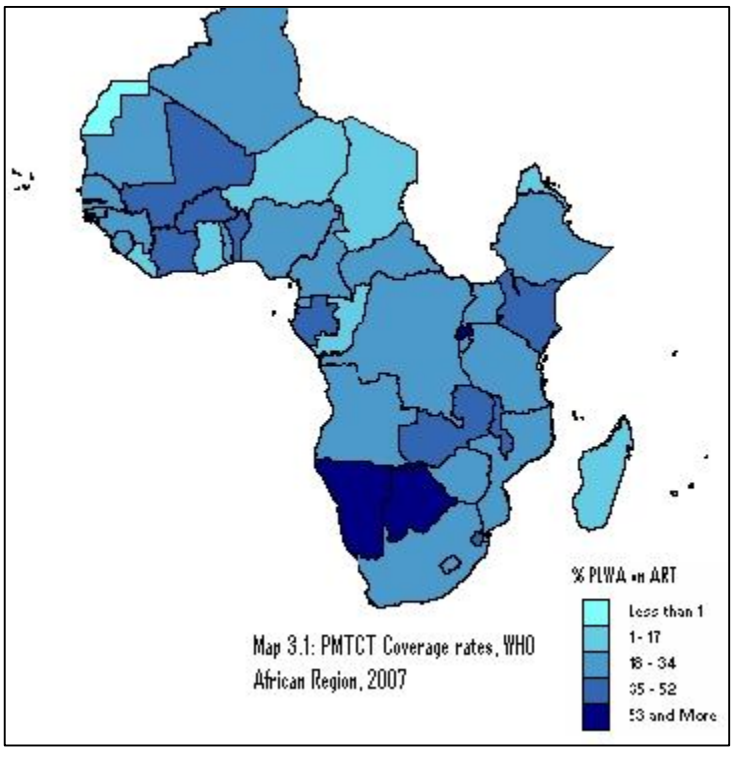
Data from 2006-2007 population-based surveys conducted in some countries of the region indicates that the proportion of men and women who received HIV test and counseling within the past 12 months preceding the survey increased to 7% each—from 3% range in similar surveys conducted earlier. With the expansion of HTC and ART sites, similar coverage rates are expected in coming years.

3.3.2 PREVENTION MOTHER TO CHILD TRANSMISSION (PMTCT)

The 2001 UNGASS Declaration committed to reduce the proportion of infants infected with HIV by 50 per cent by 2010, and to ensure 80 % of pregnant women attending antenatal care (ANC) have access to essential services to reduce MTCT.

Effective PMTCT programs consist of the following elements: primary prevention of HIV infection among women of childbearing age, prevention of unintended pregnancies among HIV-infected women, and prevention of mother to child transmission.

In 2007, over 470,000 HIV positive pregnant women reportedly received ARVs for PMTCT purposes —over 50% increase from 2006 figure of slightly over 300,000. This figure, despite representing commendable progress, it is estimated to represent only about one third of those in need of the service. Map 3.1 (on the right) shows the distribution of PMTCT coverage rates (%) in WHO African Region for 2007.



Map 3.1: PMTCT Coverage rates, WHO African Region, 2007

The median percentage of ANC facilities in 23 countries offering PMTCT services is 31—ranging from 0 to 100% (Figure 3.9). Among these countries, the total number of ANC facilities offering PMTCT services is over 8,200, with a median of 129 per country—ranging from 0 in Comoros to 1,311 in Tanzania. In Egypt, 7.3% of pregnant women receive treatment in order to reduce mother-to-child transmission, whereas the percentage is 3.3 in Somalia.

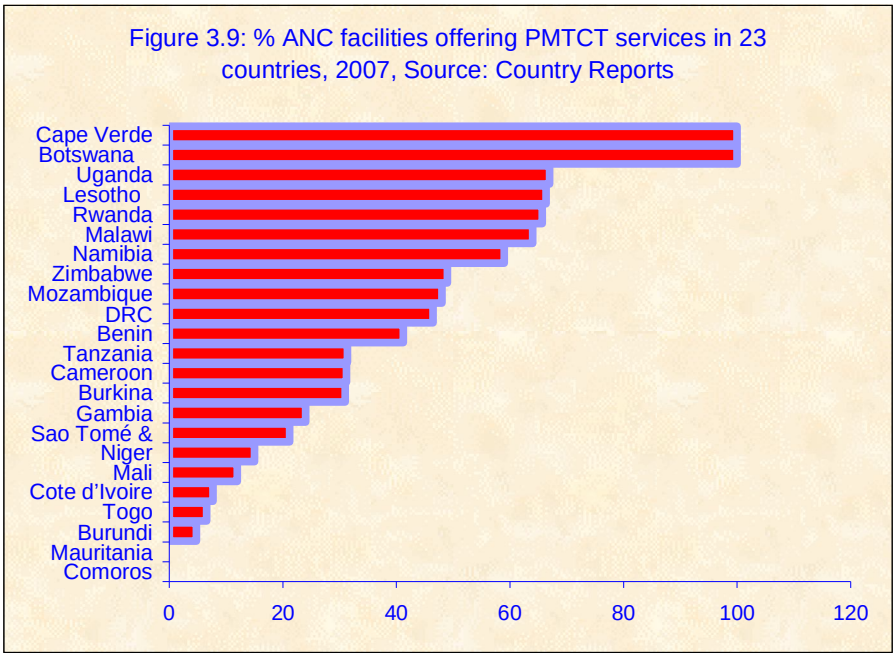
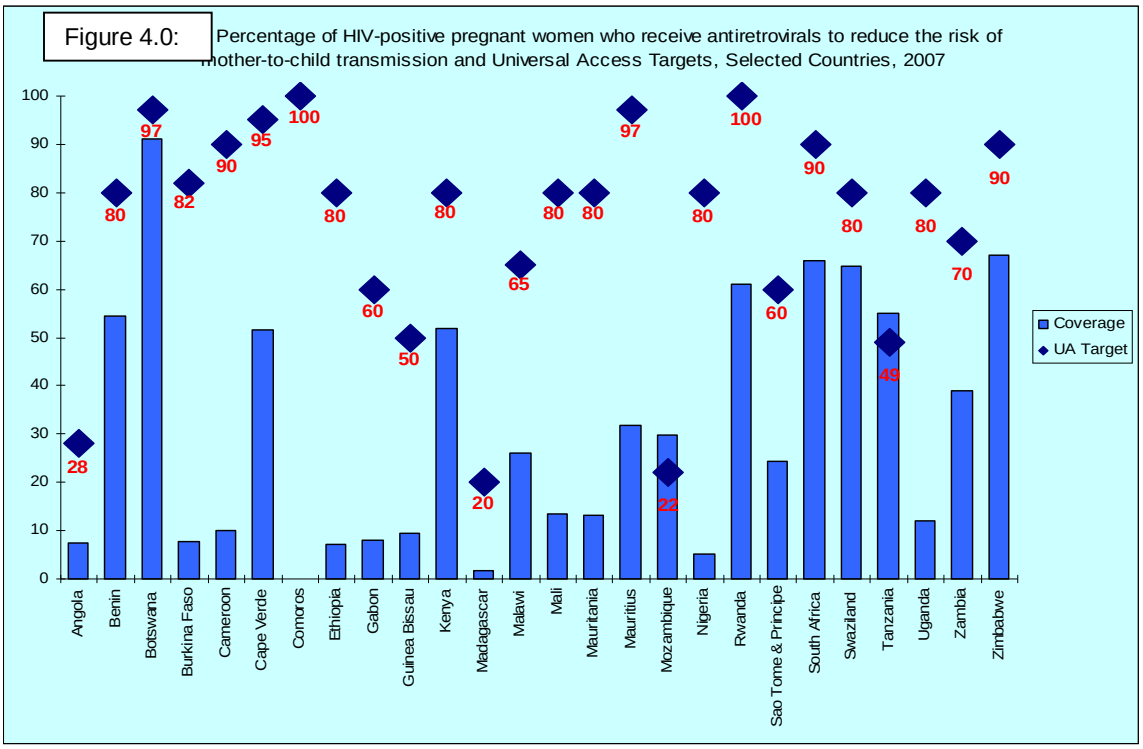
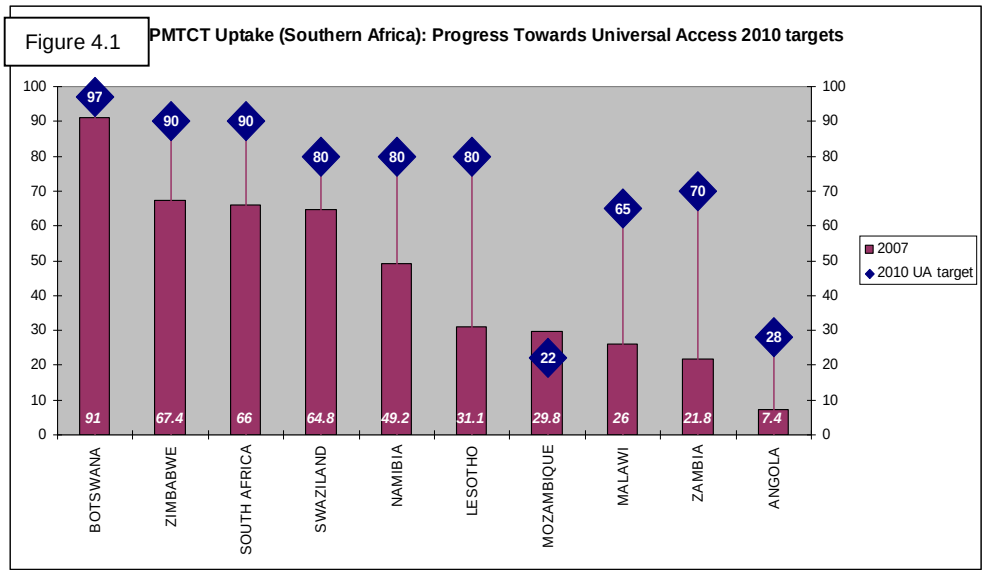


Figure 4.0 shows the progress towards the UA targets in selected countries in the region. Most countries are still quite below the target and will need to accelerate progress to reach these targets. Targets have been achieved mostly in countries with conservative targets



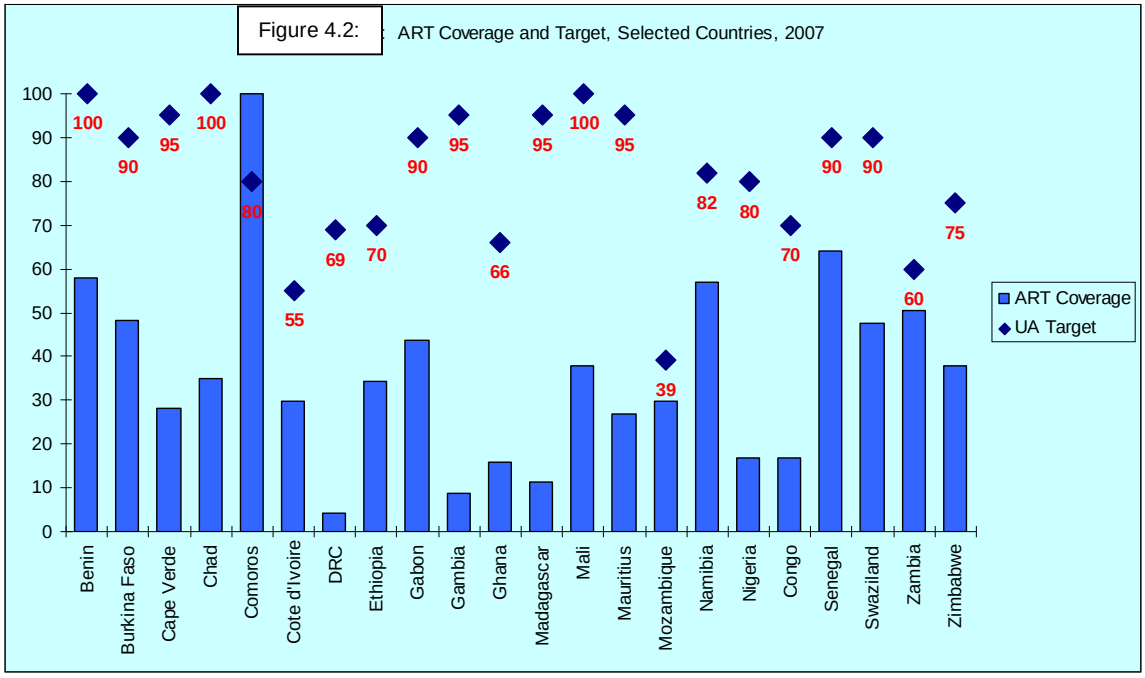
Source: 2007 UNGASS Country Reports

The chart below shows the progress East and Southern African countries are making towards universal access targets set in their respective countries (note: the figures in the diamond shape are the targets, while the bars depicts the current PMTCT uptake as reported in 2007 UNGASS reports)



3.3.3 CARE AND TREATMENT

By the end of 2007, an estimated 3 million people received ART worldwide—over 70% of these are from sub-Saharan Africa. Across the world, the number of people accessing ART has grown more than 7 times in 4 years. The bulk of this increase comes from sub-Saharan Africa, where almost 2.1 million people were receiving ART by the end of 2007. This represents a 60% increase in just one year—as 2006 saw about 1.3 million on ART.



Source: 2007 UNGASS Country Reports

WHO recommends a simplified public health approach, known as the integrated management of adult and adolescent illnesses (IMAI), to scale up anti-retroviral therapy (ART) in resource limited countries—to reduce morbidity and mortality among people living with HIV/AIDS. By the end of 2007, half of the countries in the region, were implementing IMAI, and in the process trained thousands of various health workers to manage patients with HIV/AIDS and related illnesses. Consequently, ART services have expanded to sub-district levels.

Another factor that contributed to increasing ART coverage in the region is the falling prices of ARVs and other HIV-related commodities. However, almost two thirds of people in the region who are in need of antiretroviral therapy have no access yet.

One way of measuring the level of effort countries are placing on care and treatment scale up, is the equitable expansion of ART outlets. In 2007, a total of 3,393 facilities providing ART services were reported in 35 countries—but this

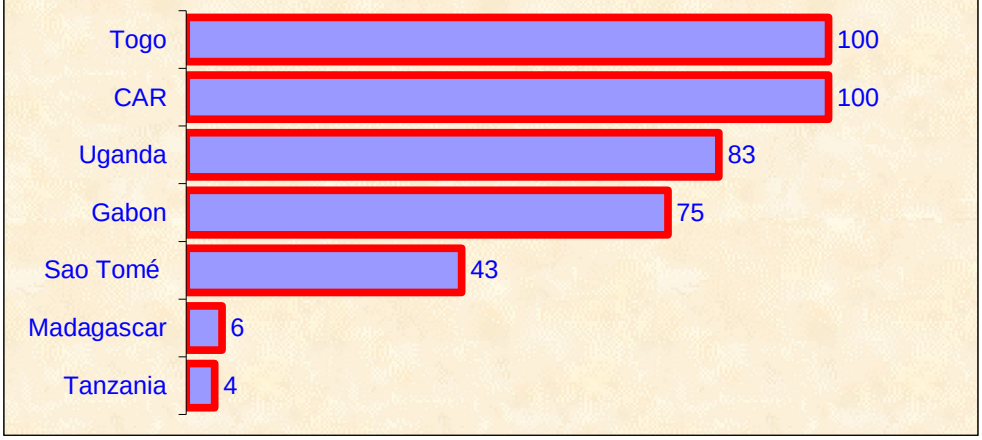
figure can easily exceed 4,000 if facilities in remaining 11 countries are included. Table 4.2 shows the distribution of number of people on ART in 2006 and 2007, percentage increase, and number of ART sites in 2007, by country. Women receiving ART in Somalia and Sudan is 1.0%. In Tunisia the figure for all women receiving ART is 34%.

3.4 ACCESS TO AFFORDABLE MEDICINE AND TREATMENT

The Global Price Reporting Mechanism (GPRM) on Antiretroviral Drugs, established in 2004, provides information on transaction prices of anti-retroviral (ARVs) medicines purchased in developing countries.

The price of first-line ARVs is continuing to fall—up to 40% in 2007. Further reductions are expected to occur in coming years as the ART scale up effort reaches the poor and disadvantaged population groups and local production of ARVs increases. Currently, up to 6 plants in the region are producing generic ARVs—mainly for local consumption, but some, like the South African plant (Aspen) has WHO pre-qualification for exports to other countries. The other 5 plants are in: Zimbabwe, Nigeria, Kenya, Benin, and Uganda.

Figure 4.3: Percent of ART sites experiencing ARVs stock outs during the past 12 months, 2007



Among the 35 countries that reported, 7 (20%) experienced stock outs of ARVs in part or all facilities that provide ART. Figure 4.3 shows proportion of ART sites that experienced stock outs of one or more ARVs during 2007. Six out of these 7 countries, reported not having provisions to address stock outs or shortages of ARVs and commodities, including test kits. Overall, half of all reporting countries (35) have procedures, which allow them to tackle such shortages or stock outs. In most of the EMRO region countries, the bulk of the costs of medicines is by the governments. Whereas in Sudan limited absorption capacity for Global Funds grants and other available financial resources may be an indicator of drugs not being available rather than affordability.

Figures 4.4 and 4.5 show progress ART uptake towards Universal Access by 2010 in Southern and Eastern Africa.

Figure 4.4: **ART Uptake: Progress towards Universal Access 2010 targets in Southern Africa**

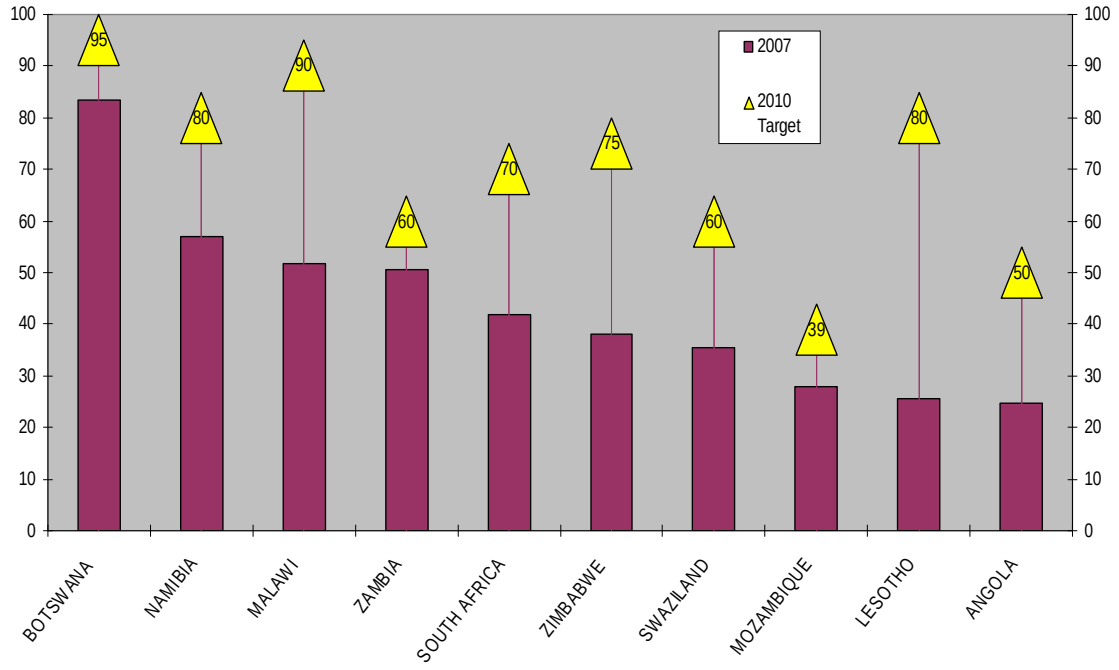
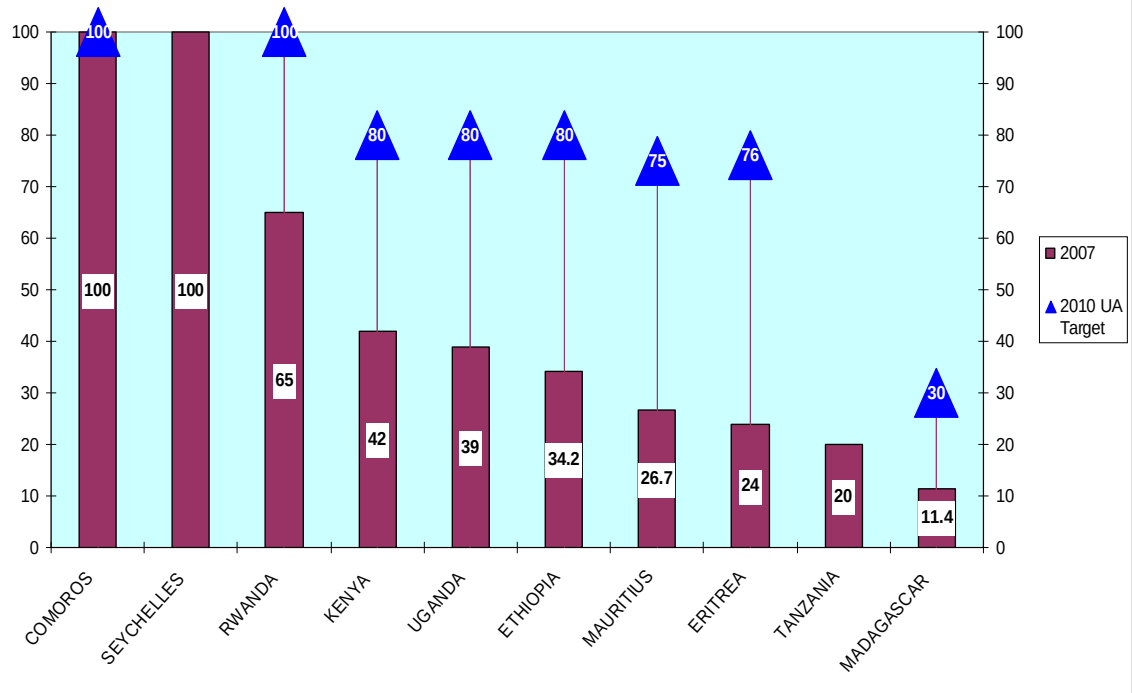


Figure 4.5: **ART uptake: progress towards Universal Access 2010 targets (East Africa)**



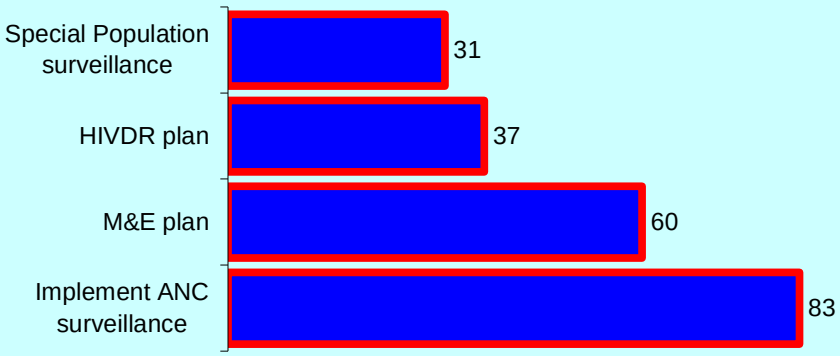
3.5 MONITORING, EVALUATIONS, AND REPORTING

Every country, in order to know its status of the epidemic, has to develop efficient strategic information systems. Strategic information system within the context of

HIV/AIDS consists of three main elements: surveillance—including HIV drug resistance, monitoring and evaluation of programs, and operational research.

Of the 35 countries that submitted the UA reporting form, 80% implement ANC surveillance by using the WHO-recommended HIV 2nd generation surveillance protocol (Figure 4.6). One third of the countries implement special population surveillance—mainly in low or concentrated HIV epidemic.

Figure 4.6: % countries with selected M&E/HIV surveillance activities, WHO African Region, 2007



In this era of ART and PMTCT scale up, the development of HIV drug resistance (HIVDR) is inevitable. In collaboration with partners, WHO has developed a global HIV drug resistance network—known as ResNet—for monitoring the magnitude of HIVDR. As of 2007, 13 countries in the region have developed national HIVDR plans.

Monitoring and evaluation (M&E) is an area that received less attention and investment in the past. Since member states have committed themselves to several global resolutions and declarations that require proper planning, establishment of effective M&E systems is inevitable. Many countries are beginning to understand the importance of M&E for program planning and tracking of the level of implementation of key interventions. About 60% of countries reported having M&E plans—in order to track the health sector response toward Universal Access for HIV prevention, care, and treatment. Sudan is in the process of improving surveillance and M & E by developing a National Monitoring and Evaluation Framework with standardized HIV core indicators. Somalia on the other hand is boosting up M & E efficacy in the response within the context of the Global Fund sub-recipients and building up Regional Partnerships in order to address HIV vulnerability and cross-border mobility in the Horn of Africa.

4. CONCLUSION

Since 2006, Member States took giant steps toward the Universal Access for HIV prevention, care, and treatment. Among documented achievements include: increased access to ART, PMTCT and HTC.

In addition, national, bilateral, multilateral commitments have increased and therefore were contributing factors of the 2007 achievements. Despite these achievements, the coverage of priority intervention—HTC, PMTCT, and ART—is still low. The number of new infections is still high and in some countries increasing. Therefore, the fight against HIV/AIDS is far from over.

5. THE WAY FORWARD

MEMBER STATES

- HTC coverage is relatively low—compared to ART and PMTCT. Provider-initiated testing and counseling (PITC) should be expanded to all public health facilities of every country
- Countries should not lose momentum of ART and PMTCT scale-up and have to continue or even increase the level of effort until Universal Access targets are fully achieved.
- Expansion of infant diagnosis, care and treatment for infected children
- Invest and strengthen strategic information, particularly in methods of understanding the dynamics of specific country's epidemics and its drivers
- Develop strategies of scaling up male circumcision, particularly in Southern Africa
- Furthermore, promote coordination and harmonization of Programmes and Partnerships through multi-sectoral and integrated approach. Regional Economic Communities and Regional Health Organizations
- Development partners and International Organizations to continue and sustain their financial and technical support to countries in Africa in order to attain Universal Access
- Promote coordination, harmonization of Regional and Continental strategies including inter-country programmes

Annexes

Table 1A: Burden of HIV/AIDS in African countries in WHO EMRO Region

Country	Estimated HIV prevalence in adult pop. (%)	Estimated number of PLWH	Reported AIDS cases 2006	Estimated no. of adults needing ART	Reported no. of people receiving ART
Djibouti	3.1	15 000	NA	2 600	492
Egypt	<0.1	5 300	88	870	166
Libya	NA	NA	NA	500	217
Morocco	0.1	19 000	291	3 300	1 530
Somalia	0.9	44 000	NA	7 100	96
Sudan	1.6	350 000	418	56 000	986
Tunisia	0.1	8 700	24	346	298

Table 1: Availability of program policy/management, including M&E, WHO/AFRO 2007

Country	Have national targets for			Have updated national policy/guidelines for			Have task shifting policy for ART expansion	Have public sector policy for free ARVs	Have national HIV M&E plan	Have national HIV Drug Resistance Strategy	HIV survey-lance
	HTC	PMTCT	ART	HTC	PMTCT	ART					
Algeria		□	□	□		□		□			
Angola					□			□			
Benin	□	□	□	□			□				□
Botswana				□	□	□	□	□			□
Burkina Faso	□	□	□	□	□	□		□		□	□
Burundi					□	□		□		□	□
Cameroon	□	□	□	□	□	□		□	□	□	
Cape Verde				□	□	□		□	□		□
CAR	□	□	□	□	□	□		□	□		□
Chad											
Comoros				□	□	□		□	□		□
Congo											
Cote d'Ivoire						□	□			□	□
DRC								□			□
Eq.Guinea											
Eritrea	□	□	□				□	□			□
Ethiopia											□
Gabon					□	□					□
Gambia	□	□	□	□		□		□	□		□
Ghana	□	□	□	□	□	□	□		□	□	□
Guinea											
Guinea Bissau	□	□	□		□	□	□	□	□		
Kenya											
Lesotho											
Liberia					□	□					
Madagascar	□	□	□		□	□		□	□		□
Malawi	□	□	□	□	□	□	□	□	□	□	□
Mali	□	□	□		□	□	□	□	□		□
Mauritania	□	□									
Mauritius											
Mozambique	□	□	□	□	□	□	□	□		□	□
Namibia	□	□	□	□		□	□	□	□		□
Niger	□	□	□		□	□		□		□	
Nigeria	□	□	□	□	□	□		□	□	□	□
Rwanda		□		□	□	□	□		□	□	□
Sao Tomé	□	□	□		□	□		□	□		□
Sénégal	□	□	□	□	□	□	□	□	□		□
Seychelles											
Sierra Leone	□	□	□		□	□	□	□	□		□
South Africa											
Swaziland	□	□	□	□	□	□		□	□	□	□

Country	Have national targets for			Have updated national policy/guidelines for			Have task shifting policy for ART expansion	Have public sector policy for free ARVs	Have national HIV M&E plan	Have national HIV Drug Resistance Strategy	HIV survey-lance
	HTC	PMTCT	ART	HTC	PMTCT	ART					
Togo	□	□	□		□	□					
Uganda	□	□	□	□	□	□		□	□	□	□
Tanzania	□	□	□	□	□	□	□	□	□	□	□
Zambia		□	□	□	□	□	□	□	□	□	□
Zimbabwe	□	□		□	□	□	□	□	□		□

Table 2: HTC and PMTCT indicators by country, WHO/AFRO 2007

Country	% HFs where HTC is available	Number of health facilities that provide HTC	% of ANC facilities that provide both HIV testing and ARVs for PMTCT	Number of ANC facilities that provide PMTCT	% of pregnant women who know their HIV status	% of HIV-infected pregnant women who received ARVs for PMTCT	Number of HIV-infected pregnant women who received ARVs during the last 12 months
Algeria		54				2.8	19
Angola	10.6	154		81	6.7	7.5	1,540
Benin	33.1	183	41.2	206	33.5	33.5	2,554
Botswana	100.0	634	100	634		89.0	12,419
Burkina Faso	30.5	454	31	400	8.1	7.7	1,426
Burundi	29.9	167	4.8	31	0.4	73.0	1,102
Cameroon	37.4	1,107	31.2	739	19.6	10.0	6,263
Cape Verde		32	100	27	68.0	47.3	9
CAR	4.1	24		62		5.1	1,867
Chad							
Comoros	21.1	4	0	0		0.0	0
Congo	21.3	54		28	4.0	2.2	175
Cote d'Ivoire	8.6	124	7.68	111		74.0	1,591
DRC	3.8	286	46.46	394	7.3	2.8	3,703
Eritrea	28.9	109			97.0	3.9	133
Ethiopia	7.9	1,005		408			5,304
Gabon	9.4	75				8.9	229
Gambia	28.0	26	24	22		100.0	350
Ghana	14.0	422		408	15.9		2,896
Guinea Bissau	28.6	34		1	34.6	12.0	430
Lesotho	79.5	163	66.34	136	91.0	31.0	3,966
Liberia	0.3	74		18			50
Madagascar	19.5	630			9.4	1.6	25
Malawi	78.3	504	64	349		45.0	10,715
Mali	7.0	58	12	103	2.0	61.1	1,151
Mauritania	4.5	22	0	0		6.0	45
Mozambique	26.8	359	48	384		7.0	12,150
Namibia	74.9	253	59	201		49.0	
Niger	6.1	145	15	129	4.0	57.0	234
Nigeria	3.2	736		253		5.3	10,500
Rwanda	69.6	312	65.66	285		73.8	5,945
Sao Tomé & Principe	91.4	32	21.21	7	88.4	24.4	22
Sénégal		190		85			264

Country	% HFs where HTC is available	Number of health facilities that provide HTC	% of ANC facilities that provide both HIV testing and ARVs for PMTCT	Number of ANC facilities that provide PMTCT	% of pregnant women who know their HIV status	% of HIV-infected pregnant women who received ARVs for PMTCT	Number of HIV-infected pregnant women who received ARVs during the last 12 months
Sierra Leone	16.5	165					919
Swaziland	67.9	110		110			10,428
Togo	5.5	51	6.6	41		6.7	697
Uganda	17.1	554	67	504	34.1	29.0	26,484
Tanzania	18.1	1,035	31.4	1,311	37.1	28.0	31,863
Zambia							306,000
Zimbabwe	48.1	791	49	771	68.0	47.0	15,381
		11,132		8,239			478,849

Table 3: ART Implementation and coverage—WHO AFRO 2007

Country	Number on ART 2006	Number on ART 2007	% increase	Number facilities providing ART
Algeria	588	993	69	7
Angola	6,514	11,540	77	56
Benin	7,634	9,765	28	47
Botswana	79,490	92,932	17	99
Burkina Faso	14,079	16,938	20	76
Burundi	8,048	10,894	35	43
Cameroon	28,403	45,817	61	109
Cape Verde	233	348	49	27
CAR	2,782	9,591	245	46
Chad	5,500	7,400	35	
Comoros	5	7	40	1
Congo	3,186	4,956	56	28
Cote d'Ivoire	36,348	67,680	86	104
DRC	17,561	28,925	65	209
Equatorial Guinea	414	985	138	
Eritrea	1,175	1,301	11	14
Ethiopia	53,720	90,212	68	272
Gabon	5,278	6,373	21	12
Gambia	400	431	8	8
Ghana	9,882	13,357	35	92
Guinea	4,699	5,660	20	
Guinea Bissau	349	890	155	12
Kenya	125,026	177,000	42	
Lesotho	17,667	21,710	23	110
Liberia	796	1,120	41	
Madagascar	92	138	50	18
Malawi	86,168	100,649	17	154
Mali	11,651	12,398	6	45
Mauritania	256	839	228	4
Mauritius	120	321	168	
Mozambique	40,891	89,592	119	211
Namibia	35,593	52,316	47	17
Niger	1,168	1,536	32	12
Nigeria	95,008	196,582	107	215
Rwanda	34,636	48,569	40	161
Sao Tomé & Principe	51	74	45	7
Sénégal	5,500	6,699	22	68
Seychelles	82	94	15	
Sierra Leone	1,416	2,649	87	81
South Africa	324,754	458,951	41	
Swaziland	18,493	24,535	33	22
Togo	6,993	7,980	14	105
Uganda	96,294	115,348	20	286
Tanzania	60,342	135,696	125	204
Zambia	82,030	151,199	84	322
Zimbabwe	66,920	103,692	55	89
	1,398,235	2,136,682	53	3,393

2008

Progress report on the Implementation of the commitments of the May 2006 Abuja Special Summit on Hiv/Aids, Tuberculosis And Malaria (ATM) Annex I Status report on HIV/AIDS in Africa

African Union

African Union