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**HIV/AIDS: FRAMEWORK FOR ACTION IN THE WHO  
AFRICAN REGION 2016–2020**

**Report of the Secretariat**

**EXECUTIVE SUMMARY**

1. HIV/AIDS continues to be a major public health concern in the African Region with almost 26 million people living with HIV and accounting for 70% of all AIDS-related deaths in the world. While there has been a decline in the number of new HIV infections, prevalence in the Region remains unacceptably high, estimated at 4.8% in 2014 but much higher in Eastern and Southern Africa ranging from 5.3% in Kenya to 27.7% in Swaziland.
2. Considerable progress has been made in the fight against HIV/AIDS with the African Region having achieved the HIV targets of Millennium Development Goal 6. New HIV infections have declined by 41% since 2000 and more than 11 million people living with HIV are receiving HIV treatment which has contributed to a reduction of up to 48% in deaths due to HIV since 2005.
3. Despite major progress, the response is heavily funded by external resources with inadequate domestic financing, the current coverage of services is inadequate and the rate of expansion is too slow to achieve regional targets. The HIV incidence continues to increase in some countries especially among adolescent girls and young women. The declines in HIV-related deaths due to treatment are being challenged by increasing morbidity and mortality associated with co-infections, such as tuberculosis and viral hepatitis. Stigmatization and discrimination continue to hinder access to health services, particularly for children, adolescents, young women and key populations such as sex workers. In addition, many countries will need to transition to domestic funding of their HIV programmes in view of the changing donor priorities.
4. In recognition of the persistent challenges, a new WHO Global Health Sector Strategy on HIV/AIDS was adopted by the World Health Assembly in May 2016. The proposed framework aims at guiding the Member States in the African Region to implement the Global Health Sector Strategy on HIV, 2016–2021. It describes actions to accelerate HIV prevention and treatment interventions in the African Region towards ending the AIDS epidemic. The actions proposed include prioritizing HIV prevention, expanding HIV testing services using diversified approaches and scaling up antiretroviral therapy by adopting innovative service delivery models.
5. The Regional Committee examined and adopted this framework.

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## INTRODUCTION

1. HIV/AIDS continues to be a major public health concern and cause of death in the African Region. Although sub-Saharan Africa is home to about 13.4% of the world's population,<sup>1</sup> it accounted for an estimated 69% of all people living with HIV (PLHIV) and 70% of all AIDS deaths in 2014.<sup>2</sup>

2. Political commitment towards the HIV/AIDS response remains high and continues to grow. This is exemplified at the global level by the adoption of the Sustainable Development Goals (SDGs) with a target of ending the HIV/AIDS epidemic by 2030.<sup>3</sup> There has also been a rapid expansion in domestic HIV/AIDS financing from Member States, and external funding particularly from the United States President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and other bilateral and multilateral sources.

3. At the regional level, the engagement of African Heads of State and Government through the Abuja +12 declaration united Member States towards the goal of eliminating HIV and AIDS, malaria and tuberculosis in Africa by 2030.<sup>4</sup> The adoption of the regional HIV/AIDS strategy at the Sixty-second session of the Regional Committee;<sup>5</sup> the adoption of the African Union catalytic framework<sup>6</sup> and the increasing allocation of domestic resources have provided further impetus to efforts aimed at scaling up intervention against HIV/AIDS.

4. A new WHO Global Health Sector Strategy on HIV/AIDS was adopted by the World Health Assembly in May 2016. The global strategy positions the health sector response to HIV/AIDS as being critical to the achievement of universal health coverage. This document provides a framework for action to accelerate HIV prevention and treatment interventions in the WHO African Region, taking into account the Regional context.

## CURRENT SITUATION

5. By the end of 2015, there was an estimated 36.7 million people living with HIV/AIDS globally. In sub-Saharan Africa there were 25.6 million PLHIV, 2.3 million of whom were children aged below 15 years, representing almost 90% of the global burden of HIV/AIDS among children. Of the 2.1 million new infections worldwide in 2015, 1.37 million (65%) occurred in sub-Saharan Africa. The overall estimate of HIV/AIDS prevalence in the Region is 4.8% but there is wide intercountry variation ranging from <0.1% in Algeria to 27.7% in Swaziland. An estimated 1.1 million adults and children died from AIDS worldwide in 2015 with 800 000 (73%) of the deaths occurring in sub-Saharan Africa.<sup>7</sup>

6. Considerable progress has been made in the fight against HIV/AIDS with the African Region having achieved the HIV targets of Millennium Development Goal 6: "Have halted by 2015 and begun to reverse the spread of HIV/AIDS".<sup>8</sup> New HIV infections have declined by 41%

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<sup>1</sup> The World Bank, World Development Indicators 2016; The World Bank Group, April 2016.

<sup>2</sup> UNAIDS, How AIDS changed everything, MDG Report 2014 ([http://www.unaids.org/sites/default/files/media\\_asset/MDG6Report\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf)) last accessed 16 February 2016.

<sup>3</sup> Resolution A/RES/70/1: Transforming our world: the 2030 Agenda for Sustainable Development; New York; September 2015.

<sup>4</sup> African Union, Abuja: Actions towards the Elimination of HIV and AIDS, Malaria and Tuberculosis in Africa by 2030, July 2013.

<sup>5</sup> Resolution AFR/RC62/R2; HIV/AIDS: Strategy for the African Region; November 2012.

<sup>6</sup> African Union: Catalytic framework to end AIDS, TB and eliminate malaria in Africa by 2030; May 2016

<sup>7</sup> UNAIDS, How AIDS changed everything, MDG Report 2014 ([http://www.unaids.org/sites/default/files/media\\_asset/MDG6Report\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf)) last accessed 16 February 2016.

<sup>8</sup> United Nations, The Millennium Development Goals Report 2015; New York, United Nations 2015.

since 2000 and the number of deaths due to HIV was cut by 48% from the peak estimate of 1.5 million deaths in 2005.<sup>9</sup>

7. In 2015, 51% of PLHIV in the African Region knew their HIV status and more than 12 million of them were receiving HIV treatment representing a coverage of 43%, up from less than 1% in 2000. More than 10 million voluntary medical male circumcisions had been performed in the 14 priority countries<sup>10</sup> and 75% of pregnant women living with HIV in the region received medicines for preventing mother-to-child transmission (PMTCT).<sup>11</sup>

8. The need to expand the response to achieve the goal of eliminating HIV/AIDS as a public health threat will need rapid implementation of HIV prevention and treatment interventions in the next five years. The regional framework builds on the extraordinary achievements made over the last 30 years. Taking into consideration the Regional context, the framework exploits the emerging and more effective approaches which have led to the development of the new global health sector strategy on HIV/AIDS.

## ISSUES AND CHALLENGES

9. Despite major progress in the response, HIV epidemics continue to pose serious public health threats in all regions. Current coverage of services is fragmented, inadequate and the rate of expansion is too slow to achieve regional targets. There continues to be a multiplicity of partner-led vertical projects, the response is heavily dependent on external resources with inadequate domestic financing, and there is inadequate balance and linkages between health sector actions and the wider multisectoral response. The full benefits of effective HIV interventions and services are not being realized. In the African Region, 13 million of the 26 million people living with HIV at the end of 2014 did not know their HIV status and 15 million were not accessing antiretroviral therapy.<sup>12</sup>

10. While HIV incidence is declining overall, it is increasing in some countries and evolving in other countries, concentrating in sub-population groups. Adolescent girls and young women in the African Region are being infected at twice the rate as that of boys and men of the same age. The HIV services are not reaching many of the populations most at risk for HIV infection. In addition, there are substantial disparities in access to treatment and care, with boys and men lagging behind in many countries.<sup>6</sup> Discrimination, stigmatization along with widespread gender-based violence, continue to hinder access to health services, particularly for children, adolescents, young women and key populations that are most at risk of HIV infection.

11. Conflict, natural disasters, emerging disease outbreaks, economic crises and climate change have triggered humanitarian emergencies in the African Region. These emergencies destroy local health systems, displace communities and force increasing numbers of people into migration with interrupted or poor access to HIV services.

12. Rapid expansion of HIV programmes without ensuring the quality of services risks undermining programme effectiveness, wasting precious resources and contributing to negative health outcomes in the Regional HIV response. This may lead to the emergence of HIV drug

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<sup>9</sup> WHO, Global health sector response to HIV 2000–2015; Focus on innovations in Africa: Progress report 2015; Geneva World Health Organisation, December 2015.

<sup>10</sup> Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

<sup>11</sup> WHO, Global health sector response to HIV 2000–2015; Focus on innovations in Africa: Progress report 2015; Geneva World Health Organisation, December 2015.

<sup>12</sup> WHO, Global health sector response to HIV 2000–2015; Focus on innovations in Africa: Progress report 2015; Geneva World Health Organization, December 2015.

resistant strains which are more expensive to manage and treat with more toxic medicines. Assuring the quality of HIV prevention, diagnostic and treatment commodities is essential as demand and use increase in the African Region.

13. AIDS deaths are declining with expanding access to antiretroviral therapy. However, investments in treatment are being challenged by increasing morbidity and mortality associated with coinfections. The common comorbidities among PLHIV include malaria, hepatitis B and hepatitis C, cancers, cardiovascular disease, diabetes, mental health and substance use disorders. Despite a scale-up in antiretroviral therapy, and improvements in the prevention and management of HIV and tuberculosis coinfection, tuberculosis is still the leading cause of hospitalization of adults and children living with HIV, and remains the leading cause of HIV-related deaths.

14. The human resource crisis facing several countries in the Region has impacted negatively on the delivery of services. Thirty-six out of the 47 countries in the African Region are among the 57 countries in the world facing a human resource for health crisis. Laboratory capacity, access to HIV diagnosis and patient monitoring such as early infant diagnosis, viral load and CD4 monitoring, remain inadequate. There is very limited local production, while procurement and supply management systems for HIV medicines and commodities remain weak, quite often leading to stock-outs.

15. Heavy reliance on donors and international financing threatens the sustainability of HIV interventions. With changing donor priorities, expanding equitable and sustainable health financing systems is particularly critical for both low- and middle-income countries in the Region. At the same time, low-income countries will continue to rely on external development assistance to ensure that essential HIV services are funded adequately.

## **THE REGIONAL FRAMEWORK FOR ACTION**

### **Vision, goal, objectives and targets**

16. **Vision:** Zero new HIV infections, zero HIV-related deaths and zero HIV-related discrimination in a region where people living with HIV are able to live long and healthy lives.

17. **Goal:** To end the HIV/AIDS epidemic as a public health threat by 2030, within the context of ensuring healthy lives and promoting well-being for all at all ages.

18. **Objectives:**

- (a) To guide the Member States in the African Region to implement the Global Health Sector Strategy on HIV, 2016–2021 as a contribution to achieving the 2030 agenda for sustainable development by ensuring universal health coverage.
- (b) To articulate the priority actions required to achieve the global HIV/AIDS strategy targets.

19. The targets of the HIV/AIDS: Framework for action in the WHO African Region 2016 – 2020 are:

### **HIV-related deaths**

- (a) HIV-related deaths reduced to below 287 000 from a 2014 baseline of 790 000.
- (b) Tuberculosis deaths among people living with HIV reduced by 75%.
- (c) Hepatitis B and C deaths among people coinfecting with HIV reduced by 10%.

### **Testing and treatment**

- (a) 90% of people living with HIV know their HIV status;
- (b) 90% of people diagnosed with HIV receive antiretroviral therapy;
- (c) 90% of people living with HIV, and who are on treatment, achieve viral load suppression.

### **Prevention**

- (a) New HIV infections reduced to 420 000 from the 2014 baseline of 1.4 million new infections.
- (b) Less than 5% new HIV infections in infants.
- (c) 90% of sexually active individuals have access to HIV combination prevention services.

### **Discrimination**

90% of people living with HIV including key populations, as defined according to national policies, report no discrimination in the health sector.

### **Financial sustainability**

- (a) 90% of all people living with HIV covered by public, social or private health insurance for antiretroviral therapy.
- (b) All countries have integrated essential HIV/AIDS services into national health financing arrangements.

## **GUIDING PRINCIPLES**

20. The guiding principles of the Regional Framework are;

- (a) Country ownership to ensure that the national HIV/AIDS response is led, coordinated and owned by the Member States.
- (b) Effective partnerships for multisectoral programming involving all sectors of society and to ensure that partners align their support to the national HIV/AIDS response as set out by governments.
- (c) Universal health coverage as the overarching framework to ensure that all people obtain the HIV/AIDS services they need without suffering financial hardship when paying for them.
- (d) Integration of HIV/AIDS services into health systems and strategies, and strengthening of the interface between the health sector and other sectors.
- (e) A public health approach based on simplified and standardized interventions and services that can readily be taken to scale and bringing them nearer to the population in need.
- (f) A people-centred approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways.

## PRIORITY INTERVENTIONS AND ACTIONS

Countries should undertake the following actions:

### *Information for focused action*

21. Strengthen national strategic information systems to provide quality, accurate and timely data. The data should be appropriately disaggregated to the district, community and facility levels by age, sex and location to better understand subnational epidemics, assess performance along the continuum of HIV/AIDS services and guide more focused investments and services. Countries should link and integrate HIV strategic information systems with broader health information systems and identify opportunities for integrated strategic information platforms.

22. Review and update the national HIV/AIDS strategies and guidelines to reflect the new national HIV/AIDS targets and priorities; develop costed action plans and report regularly on progress towards the 2020 targets. Countries should strengthen programme accountability by regularly reporting on national HIV/AIDS programme implementation, financing, performance and impact, including progress towards the 2020 targets.

### *Interventions for impact*

23. Prioritize high-impact prevention interventions, including condom programming, injection and blood safety, behaviour change communication and male circumcision. The prevention benefits of antiretroviral drugs should be maximized by accelerating antiretroviral therapy coverage, implementing pre- and post-exposure prophylaxis, and providing a comprehensive package of harm reduction services to people who use drugs.

24. Eliminate HIV in infants by providing lifelong antiretroviral therapy for pregnant and breastfeeding women living with HIV, expanding early infant diagnosis and providing immediate antiretroviral therapy for all infants diagnosed with HIV. HIV prevention for adolescents, girls and young women should be a priority using interventions that aim to reduce both vulnerability and risk behaviours, including gender-based and sexual violence.

25. Expand national HIV testing services. It is important to diversify testing approaches and services by combining provider-initiated and community-based testing, promoting decentralization of services and utilizing HIV testing services to detect other infections and health conditions. HIV testing services need to be focused on reaching populations and settings where the HIV/AIDS burden is greatest in order to achieve greater impact. All countries should ensure that HIV testing services meet ethical and quality standards.

26. Accelerate the scale-up of antiretroviral therapy for all children and adults living with HIV according to WHO guidelines and improve their retention in care to achieve the targets of the regional framework. This will require improvements in treatment adherence, use of robust and well-tolerated antiretroviral therapy regimens, effective HIV drug-resistance surveillance, toxicity monitoring systems and viral load testing to assess treatment effectiveness. To ensure the uninterrupted provision of HIV/AIDS services, local production of HIV medicines and commodities should be promoted taking into account the Pharmaceutical Manufacturing Plan for Africa (PMPA) endorsed by Member States of the African Union.<sup>13</sup> In addition, the procurement and supply management of HIV/AIDS medicines, diagnostics and other commodities should be integrated into the broader national procurement and supply management system.

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<sup>13</sup> African Union, Pharmaceutical Manufacturing Plan for Africa, Addis Ababa, African Union 2012.

27. Review and update national HIV treatment and care guidelines and protocols, including guidance on the prevention and management of common comorbidities. There should be updated treatment plans to ensure continuity of treatment, differentiated care, and a timely transition from old to new treatment regimens and approaches. Countries should provide general and chronic care services, make available the WHO Package of essential noncommunicable disease interventions for primary care, and provide community and home-based care.

28. Ensure prevention, early detection and treatment of common coinfections such as viral hepatitis, and opportunistic infections such as cryptococcus, to reduce mortality and morbidity among PLHIV. Countries should provide person-centred chronic care for PLHIV including, adequate nutrition, managing comorbidities including cancer, mental health conditions, cardiovascular disease and provide end-of-life palliative care.

29. Strengthen joint TB and HIV programming to optimize use of resources for greater impact. The 'one-stop shop' integrated TB/HIV service model is to be promoted for universal access to TB/HIV interventions such as HIV testing and counselling to all presumptive and diagnosed TB patients; systematic screening for people living with HIV; ART and preventative therapies. In addition, provide prophylactic TB treatment for PLHIV and scale up the implementation of measures for TB infection control in health care facilities.

#### *Delivering for equity*

30. Countries should strike a balance between focusing their HIV/AIDS responses for maximum impact and ensuring that no one is left behind, particularly children and adolescents, girls and women, key populations that are most at risk of HIV infection, and people living in remote areas. Priority should be given to reaching populations and locations in greatest need and overcoming major inequities. Countries should decentralize HIV/AIDS services and provide differentiated care with strong community engagement. Services should be accessible, acceptable and appropriate to realize impact. The differentiated care approach will provide tailored intervention packages to individuals at different stages of HIV disease and with different treatment needs.

31. Promote greater integration, linking and coordination of HIV/AIDS services with other relevant health areas including: sexually-transmitted infections, broader sexual and reproductive health, emergency settings, drug dependence, blood safety, noncommunicable diseases and gender-based violence. This has the potential to reduce costs, improve efficiencies and lead to better outcomes. To demonstrate genuine commitment and realize meaningful integration, the HIV/AIDS programmes should plan jointly with other programmes and implement activities collaboratively using proven integrated service delivery models.

32. Integrate HIV into national emergency plans to ensure the continuity of essential HIV services during emergencies and in settings of humanitarian concern, with a particular focus on preventing treatment interruptions. All relief workers should receive basic training in HIV/AIDS, as well as sexual violence, gender issues, and non-discrimination towards HIV/AIDS patients and their caregivers.

33. Expand and train the health workforce, including community-based workers to perform different roles across the full continuum of HIV/AIDS services. Task-shifting should be used as part of broader human resources reforms to improve service accessibility and efficiency. To ensure quality of services, supportive mechanisms need to be put in place, including mentoring, supervision of all health workers and appropriate compensation for their work.

*Financing for sustainability*

34. Develop a comprehensive HIV/AIDS investment case to advocate for adequate allocation of domestic resources and to mobilize external funding support. Countries should estimate the resource needs for fast-tracking the HIV/AIDS response in order to achieve the targets in the regional framework.

35. Develop a plan for filling any resource gap through raising new funds that should eliminate financial barriers for accessing HIV/AIDS and other health services. Countries should provide universal protection against health-related financial risk. This will include removing direct, out-of-pocket payments for accessing HIV and financial cover for all populations, especially those at high risk of HIV infection.

36. Monitor health expenditures and costs and cost-effectiveness of HIV services through the national monitoring and evaluation system in order to identify opportunities for cost reduction and saving. In addition, strengthen coordination with other health programmes and identify opportunities to consolidate underlying health systems, such as those for strategic information, human resources, and procurement and supply management.

*Innovation for acceleration*

37. Develop innovative combination prevention packages to tackle the high HIV incidence especially among adolescent girls, young women and key populations. The potential of HIV self-testing should be explored. Innovation is required along the continuum of HIV/AIDS services to develop new medicines, implement new models of service delivery, use existing tools more efficiently and adapt them for different populations, settings or purposes.

38. Participate in the development of reliable point-of care diagnostics and integrated diagnostic platforms for the combined diagnosis of HIV and coinfections, such as tuberculosis, viral hepatitis and syphilis. Countries should strengthen the collaboration between policy-makers and research institutions to generate the evidence for decision-making and accelerate the translation of research findings into policy. Member States should document best practices, promote the development, transfer, dissemination and diffusion of environmentally sound technologies and conduct study tours for south-south learning and to share knowledge for the prevention and treatment of HIV/AIDS.

39. The Regional Committee examined and adopted this framework.

**ANNEX: Key indicators for monitoring the Regional HIV response across the continuum of HIV services and including the HIV care cascade**

	<b>Area of work</b>	<b>Indicator</b>	<b>Data Sources</b>
1	Know your epidemic	Number and % of people living with HIV	<p><b>Facility/outreach reporting systems</b> – patient monitoring data, case reporting data, outreach data.</p> <p><b>Population-based surveys</b> – Demographic and health surveys (DHS), AIDS indicator surveys (AIS), integrated bio-and behavioural surveys (IBBS)</p> <p>Evaluation and modelling</p>
2	Financing	% of HIV response financed domestically	<p><b>Financial and health systems data</b> – budgets, financial records, national health accounts (NHA), National AIDS spending assessment (NASA)</p>
3	Prevention	<p>% of condom use among sexually active individuals or needles per person who injects drugs</p> <p>% of HIV negative infants born to HIV-infected women, confirmed by a virological test</p>	<p><b>Facility/outreach reporting systems</b> – health facility data, outreach data.</p> <p><b>Population-based surveys</b></p>
4	Testing	% of people living with HIV who have been diagnosed	<p>Facility/outreach reporting systems</p> <p>Population based surveys</p>
5	Linkage to care	Number and % in HIV care (including ART)	<p><b>Facility/outreach reporting systems</b> – patient monitoring data, case reporting data, outreach data.</p>
6	Currently on ART	% on ART	<p><b>Facility/outreach reporting systems</b> – health facility data, patient monitoring data, case reporting, outreach data.</p> <p>Evaluation and modelling</p>
7	ART retention	% retained and surviving on ART	<p>Facility/outreach reporting systems</p>

			Evaluation and modelling
8	Viral suppression	% on ART virally suppressed	Facility/outreach reporting systems  Population based surveys  Evaluation and modelling
9	HIV deaths	Number and ratio of HIV-related deaths	Facility/outreach reporting systems  Population-based surveys  Facility Assessments  Vital registration  Evaluation and modelling
10	New infections	Number and % of new HIV infections	Facility/outreach reporting systems  Population-based surveys  Facility assessments  Vital registration  Evaluation and modelling