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HIV/AIDS: STRATEGY FOR THE AFRICAN REGION

Report of the Secretariat

EXECUTIVE SUMMARY

1. More than thirty years into the pandemic, HIV/AIDS remains a long-term development challenge in the WHO African Region which bears 69% of the global burden and has accounted for more than 70% of the world's AIDS-related deaths. 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 2011 but much higher in Southern Africa.
2. There has been unprecedented political and financial commitment globally and in the Region towards the HIV response. This has led to scaling up of HIV/AIDS prevention, treatment and care interventions in all countries. The results are encouraging as the number of new infections is decreasing in more countries and there is a reduction in HIV-related mortality as reported in 2010. To consolidate these gains, the Region will need to intensify efforts in HIV response by mobilizing domestic resources, optimizing the synergies between HIV and other health programmes and contributing to health system strengthening.
3. A new WHO Global Health Sector Strategy (GHSS) on HIV/AIDS was adopted by the World Health Assembly in May 2011. This document, which is an update of the regional HIV/AIDS strategy, provides directions for implementing the GHSS in the WHO African Region, taking into account the key regional specificities.
5. The interventions proposed include scaling up prevention; eliminating new HIV infections in children; and expanding access to HIV testing and treatment. It is expected that this strategy will contribute to eliminating new infections among children, reducing new infections among young people and reducing HIV-related deaths. Strengthening health systems and reducing co-morbidities such as TB/HIV will be crucial to achieving the targets set in the Regional Strategy. It is proposed that the interventions be carried out in an integrated manner to maximize effectiveness. This will involve the participation of all stakeholders, including communities, under the leadership of governments.
4. The Regional Committee reviewed and adopted the proposed HIV/AIDS Strategy for the African Region.

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INTRODUCTION

1. It has been more than 30 years since the first reported HIV/AIDS cases, 15 years since Highly Active Anti-Retroviral Treatment became a reality, and six years since the United Nations political commitment to achieve universal access to HIV prevention, treatment, care and support.¹ While there has been a decline in the number of new HIV infections, the regional prevalence remains high and countries in Southern Africa continue to be the epicentre of the epidemic.² The high burden of HIV is a factor contributing to the high maternal mortality and under-five mortality in the Region.

2. Political commitment to halt and reverse the spread of the HIV epidemic remains high and continues to grow. This is exemplified at the global level by the adoption of the Millennium Development Goals (MDG). There has also been rapid expansion in AIDS financing 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. Investments in the HIV response in low- and middle-income countries rose nearly ten-fold from US\$ 1.6 billion to US\$ 15.9 billion between 2001 and 2009.³

3. At the regional level, the engagement of African Heads of State and Government through the 2006 Abuja Call for accelerated action towards Universal Access (UA) to HIV/AIDS, Tuberculosis and Malaria Services⁴ and the Decision of the 2010 Kampala African Union Assembly to extend the target year for UA to 2015,⁵ the adoption of a resolution at the 55th Regional Committee,⁶ and the increasing allocation of domestic resources have provided further impetus to efforts aimed at scaling up intervention against HIV/AIDS. The adoption of the 2008 Ouagadougou Declaration on Primary Health Care and Health Systems,⁷ affirming the principles of the Declaration of Alma-Ata, has built a regional consensus on the need to further integrate HIV service delivery within the context of health systems strengthening.

4. The WHO Regional Committee for Africa adopted the HIV/AIDS/STD Strategy in the African Region⁸ during its Forty-sixth session in 1996 and its Framework for implementation⁹ during its Fiftieth session in 2000. Subsequently, a strategy for renewal and acceleration of HIV prevention was adopted by the Regional Committee in 2006.¹⁰ The goal of the strategy was to accelerate HIV prevention and reduce the impact of HIV/AIDS by creating an enabling policy environment, increasing access to HIV treatment and prevention, strengthening health systems and increasing financial resources for the HIV response.

¹ Resolution UN A/RES/60/262, The United Nations Political Declaration on HIV/AIDS. New York, United Nations General Assembly, June 2006.

² WHO, HIV in the WHO African Region, 2011 update, Brazzaville, WHO Regional Office for Africa, 2011.

³ UNAIDS, Global Report: UNAIDS Report on the Global AIDS Epidemic, Geneva, Joint United Nations Programme on HIV/AIDS, 2010.

⁴ AU, Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and malaria Services in Africa, 2006. Special Summit of African Union on HIV and AIDS, Tuberculosis and Malaria, Abuja, Nigeria, 2–4 May 2006, African Union, 2006.

⁵ AU, 16th Summit, Kampala, Uganda, June 2010, African Union 2010.

⁶ Resolution AFR/RC55/R6, Acceleration of HIV Prevention efforts in the African Region. In: *Fifty-fifth session of the WHO Regional Committee for Africa, Maputo, Mozambique, 22–26 August 2005, Final report*, Brazzaville, World Health Organization, Regional Office for Africa, (AFR/RC55/20), pp. 14–16.

⁷ WHO, Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium, Brazzaville, Regional Office for Africa, 2008.

⁸ 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*, WHO Regional Office for Africa, 1996.

⁹ Resolution AFR/RC50/R5, HIV Prevention in the African Region: A Framework for Implementation. In: *Fiftieth session of the WHO Regional Committee for Africa, Ouagadougou, Burkina Faso, 28 August–2 September 2000, Final report*, Brazzaville, World Health Organization, Regional Office for Africa, (final report), pp. 15–18.

¹⁰ Resolution AFR/RC56/R3, HIV Prevention in the African Region: A Strategy for Renewal and Acceleration. In: *Fifty-sixth session of the WHO Regional Committee for Africa, Addis-Ababa, Ethiopia, 28 August–1 September 2006, Final report*, Brazzaville, World Health Organization, Regional Office for Africa, (AFR/RC56/24), pp. 15–18.

5. A new WHO Global Health Sector Strategy (GHSS)¹¹ on HIV/AIDS was adopted by the World Health Assembly in May 2011. The present document, which is an update of the regional HIV/AIDS strategy, provides directions for implementing the GHSS in the WHO African Region, taking into account the key regional specificities. It defines the health sector's contribution to the broader, multisectoral response to HIV/AIDS in the Region for the period 2012–2015.

SITUATION ANALYSIS AND JUSTIFICATION

Situation analysis

6. By the end of 2011, there was an estimated 34.2 million people living with HIV/AIDS (PLWHA) globally. In sub-Saharan Africa there were 23.5 million PLWHA, 3.1 million of whom were children aged below 15 years, representing almost 80% of the global burden of HIV/AIDS in children. Of the 2.5 million new infections worldwide, 1.7 million (68%) occurred in sub-Saharan Africa in 2011, with an overall prevalence of 4.8% but a wide intercountry variation ranging from <0.1% in Algeria to 35% in Swaziland. During the same year, an estimated 1.7 million adults and children died, worldwide, with 1.2 million (71%) of the deaths occurring in sub-Saharan Africa.¹² Eighty per cent of the global TB/HIV co-infections are in the Region.¹³ Women continue to be disproportionately affected by the HIV/AIDS epidemic in the Region. Data from population-based surveys show that more females were infected than males although the differences vary from country to country.¹⁴ In Zambia, for example, HIV prevalence among women aged 15–24 years was found to be nearly four times that of men in the same age group.¹⁵

7. The HIV/AIDS epidemic continues to have a profound sociodemographic and economic impact in the African Region. It is projected that average life expectancy in the Region will be 12–17 years less compared to other Regions by 2050.¹⁶ HIV/AIDS affects the economy by reducing the labour supply through increased mortality and illness. It is estimated that the impact of HIV/AIDS on the Gross Domestic Product of the worst-affected countries is a loss of around 1.5% per year.¹⁷ There is a direct effect of HIV/AIDS on the health workforce in the African Region. Botswana lost about 17% of its health workforce due to AIDS between 1999 and 2005 while a study in one region in Zambia found that 40% of midwives were HIV-positive and staff-loss rates by cadre were 30% for doctors, 36% for midwives and 33% for nurses.¹⁸ A study in South Africa found that 21% of teachers aged 25–34 years were living with HIV.¹⁹ All infected and affected workers are likely to take time off work and further absenteeism may result from psychological impact.

8. Considerable progress has been made in the fight against HIV/AIDS in the WHO African Region. On the whole, new HIV infections are decreasing in 22 countries²⁰ and stabilizing in 11 countries.²¹ This is in line with the MDG-6 target to “Have halted by 2015 and begun to reverse the spread of HIV/AIDS”. AIDS-related deaths are also decreasing in the Region with 16 countries reporting declines

¹¹ WHO, The Global Health Sector Strategy for HIV/AIDS, Geneva, World Health Organization, May 2011.

¹² UNAIDS, Together we will end AIDS, 2012, Geneva Switzerland, 2012.

¹³ WHO, Global TB Report 2011, Geneva, World Health Organization, 2011.

¹⁴ WHO, HIV in the WHO African Region, 2011 update, Brazzaville, WHO Regional Office for Africa, 2011.

¹⁵ UNAIDS (2008) report on the global AIDS epidemic (http://www.unaids.org/en/knowledgecentre/HIV_Data_Global_Report, 2008). Last accessed on 13 April 2012.

¹⁶ UNAIDS, 2006 Report on the Global AIDS Epidemic, Chapter 4; the Impact of AIDS on People and Society, Geneva, Switzerland.

¹⁷ Rosen S. et al (2004) The cost of HIV/AIDS to businesses in southern Africa (<http://journal.lww.com/aidsonline/toc/2004/01230>) AIDS 18:317–324. Last accessed on 13 April 2012.

¹⁸ UNAIDS (2006) Report on the Global AIDS epidemic, Geneva, Switzerland.

¹⁹ UNAIDS (2006) Report on the Global AIDS epidemic, Geneva, Switzerland.

²⁰ Botswana, Burkina Faso, Central African Republic, Congo, Côte d'Ivoire, Eritrea, Ethiopia, Gabon, Guinea, Guinea-Bissau, Malawi, Mali, Mozambique, Namibia, Rwanda, Sierra Leone, South Africa, Swaziland, Togo, Tanzania, Zambia and Zimbabwe.

²¹ Angola, Benin, Cameroon, Democratic Republic of Congo, Ghana, Kenya, Lesotho, Niger, Nigeria, Senegal and Uganda.

in AIDS-related mortality between 2001 and 2009, ranging from 11% in the Republic of Congo to 72% in Rwanda.²²

9. By the end of 2011, access to antiretroviral therapy in the Region had increased fifty fold from 100 000 in 2003 to 6.2 million, i.e. 56% of the total of 10.4 million people estimated to be in need.²³ Botswana, Comoros, Namibia and Rwanda have achieved universal access to antiretroviral therapy and 12 countries have coverage rates exceeding 50%,²⁴ showing that rapid scale up using a public health approach is feasible. The percentage of pregnant women living with HIV who received medicines for preventing mother-to-child transmission (PMTCT) increased from 15% in 2005 to 60% in 2010. Seven countries²⁵ exceeded the 80% coverage in achieving the universal access target of coverage with effective regimens of antiretroviral medicines.

10. Despite these gains, the impact of the HIV/AIDS epidemic continues to be severe. HIV prevention interventions are still fragmented and inadequate, especially for key populations. There continues to be a multiplicity of partner-led vertical projects and there is inadequate balance and linkages between health sector actions and the wider multisectoral response. Access to HIV treatment is less than 50% and most people are unaware of their HIV status. There is also the interaction of HIV/AIDS with other communicable diseases like tuberculosis, malaria, Hepatitis B, Hepatitis and noncommunicable diseases like cancers and others that need to be managed.

11. The human resource crisis facing several countries in the Region has impacted negatively on the delivery of services. Thirty-six out of the 46 countries in the African Region are among the 57 countries in the world considered as facing a human resource for health crisis.²⁶ Laboratory capacity for and access to HIV diagnosis and follow up, including for early infant diagnosis and CD4 monitoring, remain inadequate and procurement and supply management systems for HIV medicines, including those for opportunistic infections, and commodities remain weak, quite often leading to stock-outs. Weak health information systems hamper effective monitoring of progress.

12. Over-dependence on donors and international funding jeopardizes the sustainability of HIV interventions, particularly in the context of the cancellation of the Global Fund Round 11 application. For example, it is estimated that in low-income countries, 88% of spending on HIV/AIDS came from international funding in 2010.²⁷ Domestic funding to fill the resource gap and sustain the response is still low in the Region. In addition, high levels of gender inequity, stigma and discrimination persist and interventions for them remain inadequate.

Justification

13. The new WHO Global Health Sector Strategy on HIV/AIDS, adopted in May 2011, has the overarching goal of achieving universal access to HIV prevention, diagnosis, treatment and care by 2015. The global strategy seeks to guide the health sector's contribution to the vision of a world with zero new infections, zero AIDS-related deaths and zero discrimination as articulated in the UNAIDS Strategy for 2011–2015.²⁸

14. In addition, new approaches have emerged and led to new global goals and commitments that necessitate updating the Regional Strategy. These include the elimination of mother-to-child transmission of HIV (eMTCT) and keeping HIV-infected mothers alive, providing services for medical

²² WHO, HIV in the WHO African Region, 2011 update, Brazzaville, WHO Regional Office for Africa, 2011.

²³ UNAIDS, Together we will end AIDS, 2012.

²⁴ Benin, Gabon, Guinea, Kenya, Lesotho, Malawi, Senegal, South Africa, Swaziland, Togo, Zambia and Zimbabwe.

²⁵ Botswana, Lesotho, Namibia, South Africa, Swaziland, Tanzania and Zimbabwe.

²⁶ WHO, World Health Report, 2006, Geneva, World Health Organization, 2006.

²⁷ UNAIDS; Global Report, UNAIDS Report on the Global Epidemic, Geneva, Switzerland, 2010.

²⁸ UNAIDS; UNAIDS Strategy, 2011–2015; UNAIDS, Geneva, Switzerland, 2010.

male circumcision, adopting *combination prevention* (i.e. combining behavioural, biomedical and structural HIV prevention interventions), using antiretrovirals for prevention, starting treatment early to improve survival and the quality of life, and giving increasing attention to noncommunicable diseases in PLWHA.

15. There is a need to reshape the HIV/AIDS response by integrating services into health systems, decentralizing services, selecting and scaling up efficient approaches, and meeting the needs of all communities without discrimination. The above developments have necessitated the updating of the Regional HIV/AIDS Strategy in order to align it with the GHSS and broader strategic frameworks²⁹ and intensify efforts in the health sector response to HIV/AIDS, with a stronger focus on the needs of women, girls and other key populations.

THE REGIONAL STRATEGY

Vision, aims and targets

16. The Regional Strategy shares the vision of the GHSS, 2011–2015, which is “Zero new HIV infections; zero AIDS-related deaths and zero discrimination in a world where people living with HIV are able to live long, healthy lives”.

17. The aims are:

- (a) to accelerate national HIV responses and advance progress in achieving country targets for universal access to HIV prevention, treatment, care and support;
- (b) to contribute to achieving Millennium Development Goal 6 and other health-related Goals, associated targets and to addressing the broader determinants of health.

18. The targets set for 2015 for the Region, which are based on the 2009 baseline data and are in line with the global targets, are to reduce:

- (a) the percentage of infected young people aged 15–24 years by 50%;
- (b) new HIV infections in children by 90% with special emphasis on those aged below two years;
- (c) HIV-related deaths by 25%; and
- (d) HIV-related tuberculosis deaths by 50%, compared with the 2004 baseline.

Guiding principles

19. The guiding principles of this strategy are:

- (a) **A human-rights approach towards Universal Access:** Promoting a human rights-approach, including equitable access to quality services of the highest standards possible to all populations.
- (b) **Integrated service delivery:** Delivering HIV services by integration into health systems, establishing strong linkages with other priority programmes, and strengthening the interface between the health sector and other sectors.
- (c) **Efficiency in resource use:** Maximizing results and achieving the greatest health impact with optimal use of the available human, financial and technological resources.

²⁹ Millennium Development Goals and Universal Access Commitments.

- (d) **Decentralization:** Strengthening local capacity and delegation of responsibility to operational levels to improve the delivery of quality health interventions and services.
- (e) **Community participation:** Empowering communities and civil society, including PLWHA, to play their roles in scaling up interventions at all levels.
- (f) **Country ownership and effective partnerships:** Ensuring that partners align their interventions to national strategic frameworks for the response, coordination mechanisms, and monitoring and evaluation systems as set out by government.

Interventions

20. There is need to expand the coverage and improve the quality of HIV services in order to achieve the regional aims and targets. In order to do this, two main approaches need to be adopted: (a) implementing priority interventions related to service delivery; (b) taking actions to strengthen the capacity of health systems in order to deliver related services.

Priority HIV/AIDS-related interventions

21. **Scale up HIV prevention.** Combining behavioural, biomedical and structural HIV prevention interventions tailored to national epidemics is the most effective approach to reducing new infections. Interventions should be broadened to include health promotion, behaviour change counselling, quality-assured HIV testing and counseling, male and female condom programming, safe voluntary medical male circumcision (in high HIV-prevalence settings with low male circumcision rates), and early initiation of antiretroviral therapy. In addition, health services should implement infection control and related procedures including standard precautions, injection and surgical safety, blood safety, safe waste disposal and post-exposure prophylaxis for occupational exposure to HIV.

22. **Eliminate mother-to-child-transmission (eMTCT) and improve maternal and child survival.** Countries should scale up approaches to PMTCT, including setting national targets to eliminate HIV in children and enable HIV-infected mothers to live longer. Key components should include preventing HIV infection in women of child-bearing age and providing them with HIV testing and counselling services, preventing unintended pregnancies, reducing HIV transmission from women with HIV to their infants, adopting safe infant feeding policies, and providing appropriate early treatment and care for women living with HIV, their children and families. It is vital to integrate these interventions into maternal, newborn and child health, sexual and reproductive health, and other health services. These will have a positive impact on MDGs 4 and 5.

23. **Expand access to diversified HIV testing and counselling services.** HIV testing must be voluntary, confidential and accompanied by appropriate counselling, whether initiated by the client or the provider. Accelerated testing and counselling services with short intervals between testing and provision of test results for adults and children is required for prevention, early diagnosis and referral to care and treatment programmes. Tailoring counselling and testing services to specific populations at high risk of HIV infection including discordant couples, sex workers, intravenous drug users, men who have sex with men, and men and women in uniform will be needed in order to improve uptake and ensure retention in care.

24. **Expand and optimize HIV treatment and care for children, adolescents and adults.** Countries should update their national HIV treatment protocols on the basis of up-to-date WHO guidelines and prepare implementation plans and mobilize resources for scale up. Antiretroviral therapy should be started early so as to reduce HIV-related morbidity and mortality and maximize the preventive impact on HIV and tuberculosis epidemics. Treatment should include the simplest, most tolerable and robust drug regimens recommended by WHO and simplified point-of-care and laboratory-based

diagnostics and monitoring tools. Nutritional care and support should be provided to enhance treatment effectiveness, adherence, retention in care and quality of life.

25. **Reduce co-infections and co-morbidities among people living with HIV.** Countries should invest in inputs, processes and capacities to manage co-morbidities. Treatment and care programmes should include prophylaxis (including immunization, vector control, and Cotrimoxazole and Isoniazid prophylaxis), diagnosis and treatment of common opportunistic infections and co-morbidities. Of particular importance is the diagnosis and treatment of tuberculosis, pneumonia, diarrhoea, malaria, viral hepatitis, malnutrition and other clinical conditions that have a more serious impact in people living with HIV. HIV services should also screen for common malignancies and assess, prevent and manage mental disorders.

26. **Strengthen TB and HIV collaborative activities.** Joint policies, training programmes and procedures for TB and HIV collaborative activities should be strengthened to prevent and manage HIV/tuberculosis co-infection. Surveillance of HIV infection among tuberculosis patients and tuberculosis prevalence among people living with HIV should be conducted, and monitoring and evaluation systems should be harmonized.

27. **Provide comprehensive care and support for people living with HIV with community participation.** HIV-related palliative, community-based and home-based care should include a multidisciplinary approach to meet all the needs of people living with HIV. Strengthening community care systems, including the capacity of community-based and home-based carers, is essential to the delivery of integrated, decentralized services, reduction of numbers of patients lost to-follow-up, expanding national HIV responses and improving health outcomes. 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.

28. **Provide comprehensive HIV/AIDS package of interventions to meet the needs of key populations.** Countries should continue to identify key populations underserved by current HIV programmes in both generalized and concentrated epidemics. The needs of young people including orphans and women should explicitly be addressed in national HIV responses. Countries should also consider the needs of migrant workers, refugees or populations displaced during humanitarian crises, street children, sex workers, men who have sex with men, injecting drug users, disabled people, prisoners and people above 50 years of age.

Actions to strengthen the capacity of health systems to deliver HIV/AIDS interventions and services

29. HIV/AIDS services should be integrated into health systems components (health service delivery; health workforce; health information systems; access to essential medicines; health systems financing; and leadership and governance), and decentralized to lower-level facilities as well as communities with referral services strengthened. First line and district health workers will have to be trained to use integrated approaches. In addition, health service delivery has to be adapted to the delivery of chronic care. The capacity of countries to better articulate their resource needs for health systems strengthening will have to be improved to boost resource mobilization. The following actions should be taken:

30. **Strengthen the stewardship and leadership role of government.** The leadership role of ministries of health should be strengthened to include defining priorities, formulating appropriate policies and developing plans using a consultative and participatory process, ensuring alignment of the actions of the various partners and stakeholders to these priorities and plans, allocating resources and ensuring their appropriate use, monitoring and ensuring progress and accountability for results.

31. **Strengthen human resources for health.** Particular attention should be paid to ensuring the availability of human resources in the right numbers and mix and competent to work with people living

with HIV and affected populations by integrating HIV content into pre- and in-service training. Appropriate policies, including recruitment and task shifting/sharing, that address the human resource crisis should be adopted. HIV/AIDS programmes should be an entry point for scaling up the availability, performance and retention of the health workforce in the context of health systems strengthening. District health management 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.

32. **Reinforce the procurement and supply management systems and strengthen laboratory capacity.** There is need to strengthen the capacity for estimation and projection of requirements, the use of information on best prices and suppliers in order to ensure availability of quality diagnostics, medicines and commodities. Countries should explore the existing flexibilities in the agreement on TRIPS and in the Doha Declaration for compulsory licensing and parallel importation of medical products. Quality control systems for diagnostics and medicines should be strengthened. Countries should ensure that the needs for strengthening and decentralizing laboratory services are adequately addressed in a comprehensive implementation plan and that capacity for maintaining all types of medical and laboratory equipment is strengthened.

33. **Strengthen strategic information systems** to track the progress of the epidemic, the implementation and outcomes of interventions, HIV drug resistance and adverse outcomes of medicines. Countries should undertake regular programme reviews and generate evidence through research to enhance knowledge of the epidemic as the basis for developing and reviewing appropriate policies and plans towards the HIV/AIDS response.

34. **Include gender and human rights issues in the design, delivery and monitoring of health services.** HIV programmes should promote equity in sexual decision-making, including negotiation of safer sex and use of male and female condoms, and establish effective linkages with programmes addressing gender inequity. There will be a need to introduce services relating to gender-based violence, including comprehensive services for survivors of rape and other sexual violence, including in conflict and other emergency situations. National HIV response should include implementing and monitoring policies and practices aimed at eliminating stigmatization, discrimination and other human rights abuses in health service delivery. Policies aimed at addressing other underlying social determinants, including poverty and gender inequality, need to be integrated into HIV/AIDS programmes.

Roles and responsibilities

Member States

35. Member States have the responsibility of ensuring that health systems have the capacity to deliver services. Governments should ensure stewardship and leadership, and forge partnerships with civil society and PLWHA for developing plans. They also have to mobilize and allocate the necessary human, material and financial resources for implementation, including both internal and external resources for accelerating HIV/AIDS interventions. Governments should ensure effective coordination of interventions. The health sector should provide technical guidance for the implementation of this updated HIV strategy, within the framework of intersectoral collaboration in the multisectoral response. Countries should be responsible for developing appropriate policies and tools, updating strategic plans for universal access, implementing planned activities, monitoring programmes, and coordinating all partners.

The World Health Organization and other partners

36. WHO should continue to provide technical leadership and normative guidance for developing plans of action, implementing programmes, monitoring and evaluation. WHO and other partners,

including UNAIDS and other UN agencies, PEPFAR, the Global Fund, Bill and Melinda Gates Foundation, and bilateral and multilateral donors should provide harmonized support to countries in resource mobilization, planning, and strengthen national government capacity to implement and coordinate the proposed priority interventions.

Resource implications

37. Based on UNAIDS estimates on the costs of implementation of a package of essential HIV/AIDS interventions in low- and middle-income countries and the contribution of the Region to the global burden, it is estimated that implementing this updated strategy in the Region in order to reach universal access by 2015 will cost about US\$ 10–12 billion per year.^{30 31} Countries should continue to strive to achieve the Abuja Declaration target of allocating 15% of their national budgets to the health sector. Additional resources need to be mobilized from development partners for overall health system strengthening, including human resources for health and improvement of infrastructure. Efforts should be made to meet the costs of providing key health services including those needed to fight the AIDS pandemic, estimated at US\$ 44 per person per year in 2009 and projected to rise to US\$ 60 per person per year by 2015.³² Innovative methods of mobilizing funds from the private, corporate sector and communities should be pursued. Countries should put emphasis on efficient resource utilization and equitable reallocation of existing resources while strengthening the country's capacity to absorb additional resources.

38. Following the adoption of the GHSS, WHO has developed an Operational Plan³³ that outlines WHO's priority work areas and provides details regarding the normative guidance, policy advice, technical assistance and other products and services that will be implemented across WHO's HIV Programme and the three levels of the Organization. The overall costs of WHO support to Member States in implementing the GHSS since its approval in May 2011 to the end of 2015 have been estimated to be US\$ 515 million. The costing for the 2012-2013 biennium is estimated at US\$ 175 million. It is expected that 28% of this amount will be required for WHO's work in the African Region.

Monitoring and Evaluation

39. Progress in moving towards the targets set out in this strategy will be assessed through periodic reviews and annual reporting. The indicators on availability, coverage, outcome and impact of the interventions, including those for equity, have been defined and agreed on globally. These will guide the monitoring of the strategy using the existing systems in place.

CONCLUSION

40. The burden of HIV/AIDS and its impact continues to pose a major challenge to the African Region. The epidemic has seriously undermined the 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.

41. The Region has witnessed unprecedented political and financial commitment towards the HIV/AIDS response with remarkable results leading to the reduction of new infections, declining AIDS-related deaths and improved quality of life for those living with HIV. However, intensified efforts are still needed in HIV prevention, treatment, care and support in order to reduce new infections, eliminate new infections in children and reduce HIV-related mortality using the interventions proposed in this

³⁰ UNAIDS, What Countries need: Investments needed for 2010 targets, Geneva, UNAIDS, 2009.

³¹ UNAIDS, World AIDS Day Report 2011, Geneva, UNAIDS, 2011.

³² The Constraints to scaling up the health MDGs: costing and financial gap analysis. Geneva, WHO, 2010: Background document for the Task Force on Innovative International Financing for Health Systems.

³³ WHO's HIV Operational Plan, 2012/13—Implementing the Global Health Sector Strategy on HIV, 2012.

document. The continued strengthening of health systems is fundamental to efficient delivery of the proposed interventions.

42. The Regional Committee reviewed and adopted the proposed HIV/AIDS Strategy for the African Region.