

# Combination Prevention in Eastern and Southern Africa



Combination prevention in Eastern and Southern Africa asserts the importance of combining a number of proven social and medical approaches to achieve maximum impact on HIV prevention.

Coordinated evidence-informed strategies that work in concert towards shared prevention goals in the context of a well researched and understood local epidemic will have the best chance of success. Resources and efforts should prioritize these approaches rather than those for which evidence of impact is weak.

The starting point is sound analysis of what is driving the epidemic in different contexts – modes of transmission modeling and other “know your epidemic”, “know the evidence” and “know your responses” synthesis reviews.

In the context of hyper-endemic and highly generalized epidemics, two factors stand out as critical drivers: multiple concurrent partnerships including age-disparate sex, with low condom use; and lack of male circumcision.

In concentrated epidemics, most transmission takes place within the key populations of sex workers and their clients, men having sex with men including prison populations and, to a much smaller but growing extent in this region injection drug use.

Interventions need to be appropriate to the epidemic context and address the right population groups with the most effective combination of strategies. This means prioritizing for scale up, quality delivery and close monitoring and evaluation those with the greatest likelihood of success: depending on epidemic context, these include socio-cultural and behavioral communication strategies to change norms and behaviors around sexual partnerships; providing safe male circumcision in the context of wider sexual and reproductive health services; strategic condom programming; raising realistic risk perceptions and awareness; and ensuring availability and uptake of PMTCT services.

## *Focus on Modes of Transmission*

The primary motivation for initiating the Modes of Transmission (MoT) process was the recognition that, in many countries, there is a lack of alignment between programmatic and financial HIV prevention needs and the prevailing prevention responses. Significant resources continue to be invested in a variety of biomedical and behavioral prevention interventions that are not systematically evaluated for their impact or quality. At the same time, efforts at addressing underlying social norms that hinder the capacity of individuals to prevent HIV infection or to deliver services consistent with human rights and service standards remain weak, inconsistent or completely absent .

The five-country MOT process (in Kenya, Lesotho, Mozambique, Swaziland and Uganda) supported by UNAIDS and GAMET between June 2007 to October 2008 aimed to develop a stronger understanding of the local epidemic in each country and undertake a critical review of the prevention response in light of evidence on the epidemic. The strategic result for this process remains improved policy decisions to support an effective HIV prevention response.

In addition, the MoT process aimed to build capacity within countries and tools for the region to be able to undertake similar studies in the future as a regular part of HIV response reviews. Within the five MOT countries, this aspect of the process focused on capacity to “synthesize” information on the epidemic, response, policy and resources; capacity to interpret the findings of the synthesis and capacity to translate this knowledge into practical recommendations.

Each country conducted the four following reviews with the aim of developing a single analytical synthesis report:

1. **Epidemiological review:** analysis of national behavioral, biological, socio-economic and demographic data to identify and explain the factors involved in driving the local epidemic.
2. **Incidence modeling:** use of national HIV and STI prevalence and behavioral data to determine the likely distribution of HIV infections in the adult population (aged 15 – 49 years) based on modes of HIV transmission.
3. **Prevention Response Review:** analysis of the scope and scale of the key prevention interventions implemented in the country and the prevention policy and strategic information environments.
4. **Response review:** analysis of the degree of alignment of national prevention resources with the priorities highlighted by this evidence.

Each of the five participating countries has produced draft national HIV synthesis reports that will feed into key national planning processes including joint annual reviews, national prevention meetings and prevention strategy development.

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## Key findings by country

**KENYA:** National adult prevalence at 6.7%. Heterosexual transmission is the most prominent mode of transmission in all areas of Kenya but is driven by casual and long-term partnerships. Multiple concurrent partnerships is a primary driver of the epidemic bridging infection from individuals involved in higher risk behavior (casual sex, sex work) and their partners. Marked regional variations in prevalence linked to variation in practices including concurrency, male circumcision. Less than 25% of all AIDS funding spent towards prevention. Minimal funding provided for youth programmes and community mobilization while largest proportion given towards facility-based prevention for example the prevention of mother to child transmission and HIV testing and counseling. Negligible resource are available for interventions focused on injection drug use and men who have sex with men despite evidence of relevance of both to new infections particularly in urban areas.

**LESOTHO:** National adult prevalence is 23.2%. Casual sex is the largest contributor to new infections in Lesotho. High rates of multiple concurrent partnerships, low rate of condom use and low male circumcision combine to create extremely high levels of risk for infection in high-prevalence Lesotho. There are a large number of policies to support prevention but Lesotho lacks an operational strategy. There is an absence of policy to guide the response to address concurrency and the underlying cultural norms. Only 13% of the national AIDS budget is used for prevention with the primary focus on the expansion of services (including PMTCT and HIV counseling and testing) and behavior change with very limited evaluation.

**MOZAMBIQUE:** National adult prevalence is 16% but with significant regional variation in prevalence and trends. Casual and long-term heterosexual partnerships are the predominant modes of HIV transmission although sex work also contributes significantly through direct infection in sex workers, their clients and indirectly, infections in regular partners of clients. High male circumcision associated with reduced levels of infection in northern region while high prevalence of STI, multiple concurrent partnerships and mobility both contribute to high levels of infection and growing trends in infection in the central and southern provinces. The prevention response targets the general population and focuses on youth abstinence, counseling and testing, condoms and STI services but minimal resources are used to address injection drug use, men who have sex with men, sex work or partner reduction.

**SWAZILAND:** National adult prevalence is 26%. Women particularly are disproportionately at risk of infection compared to men. Life expectancy has fallen to 37 years. Casual and long-term heterosexual partnerships are the key modes of HIV transmission with the majority new infections occurring in older adults (aged 25 years and older). Condom use is higher with non-regular and commercial partners; multiple partnerships are very common and are culturally supported for men; while overall levels of male circumcision are low. Seasonal migration patterns associated with additional partners add to these factors to create extremely high risk for infection and transmission. There is insufficient attention to partner reduction in the prevention response and inadequate targeting of older adults (those aged 25 years or older).

**UGANDA:** National prevalence is at 6.1% – 6.5%. Declining trends in prevalence appear to have stopped with some regional ANC data recording rising prevalence. Increased multiple concurrent partnerships have been reported. Casual and long-term heterosexual relationships are the main modes of transmission particularly affecting older populations although sex work also contributes significantly to new infections. High HSV-2 of 44% has fueled the epidemic. No policies exist to guide media and IEC, behavior change interventions, male circumcision or interventions for key populations most at risk of HIV exposure (including injection drug users,

## Key references and links

NAC, GAMET, UNAIDS, *Analysis of HIV Prevention Response and Modes of HIV Transmission: Kenya Country Synthesis*, Abstract July 2008

NAC, GAMET, UNAIDS, *Analysis of HIV Prevention Response and Modes of HIV Transmission: Lesotho Country Synthesis*, Abstract July 2008

NAC, GAMET, UNAIDS, *Analysis of HIV Prevention Response and Modes of HIV Transmission: Mozambique Country Synthesis*, Abstract July 2008

NAC, GAMET, UNAIDS, *Analysis of HIV Prevention Response and Modes of HIV Transmission: Swaziland Country Synthesis*, Abstract July 2008

NAC, GAMET, UNAIDS, *Analysis of HIV Prevention Response and Modes of HIV Transmission: Uganda Country Synthesis*, Abstract July 2008

GAMET, UNAIDS, *Analysis of HIV Prevention Response and Modes of HIV Transmission: Uganda Country Synthesis*, Abstract July 2008

UNAIDS and GAMET, *Analysis of HIV Prevention Response and Modes of HIV Transmission: The UNAIDS-GAMET Supported Synthesis Process*, Abstract July 2008

## Preliminary Recommended Actions

### 1. Planning

There is a need for presentation and constructive dialogue around the findings of MOT analysis to ensure realignment of focus and resources around prioritized, well-evaluated and well-designed interventions. Coordination of prevention is essential and mechanisms for coordination of technical guidance need to be formalized to ensure better evidence-informed direction is provided to strategic planning and review.

### 2. Programmes

Multiple concurrent partnerships and male circumcision are priorities for all five nations and their policies, guidance and standards need to be defined in-country to ensure effective communication and service delivery.

### 3. Strategic Information

The management of information on prevention is essential to ensure ease of access and control of quality of information used for decision making. Capacities for data analysis need to be continually strengthened and tools for analysis of the epidemic particularly around measurement of incidence need to be made widely available. Data needs to be strengthened to improve understanding of dynamics of epidemic in key populations most at risk for exposure (including injection drug users, men who have sex with men and sex workers) as well as at sub-national level and with mobile or transient communities, for example fishing and mining communities.

### 4. Leadership, Advocacy and Resource Mobilization

Priority attention is required to address gender-based disparities in vulnerability. Evidence must be appropriately packaged and used to engage and support leaders to act and mobilize response. Appropriate technical support and learning opportunities must be made available to ensure that high level national capacities for analysis and planning around prevention are developed, sustained and retained.

*This brief is one of a series designed to offer an overview of the key interventions needed as part of a combination prevention approach in the countries of Eastern and Southern Africa with high HIV prevalence. Others in the series include: Focus on Women and Girls; Focus on Male Circumcision; and, Focus on Multiple Concurrent Partnerships. They are available at [www.unaidsrstes.org/thematic-prevention](http://www.unaidsrstes.org/thematic-prevention)*