

**CONSEIL NATIONAL  
DE LUTTE CONTRE LE SIDA  
(NATIONAL COUNCIL FOR  
THE FIGHT AGAINST AIDS)**

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**PERMANENT EXECUTIVE  
SECRETARIAT**

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**REPUBLIC OF CONGO**

Unité\*Travail\*Progrès  
(Unity\*Work\*Progress)

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# **NATIONAL REPORT ON UNGASS**

Brazzaville, January 2006

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## **I. Summary of the state of the situation**

The Republic of Congo straddles the equator in central Africa and covers 342,000 Km<sup>2</sup>. Its population was estimated at 2,854,000 inhabitants in 2003 with 51% women and 49% men and an estimated annual population growth rate of 3.2. More than about 80% of the population live in the large towns. Average population density is estimated at 8.4 inhabitants per Km<sup>2</sup>.

The Congo's response to the HIV/AIDS epidemic goes back to 1984 with the discovery of the first cases of AIDS in patients transferred to France.

From 1985, a committee for the Diagnosis and Fight against AIDS was set up. In 1985, the Programme National de Lutte contre le SIDA (PNLS) (National Programme for the Fight against AIDS) and the MST were created. From the time of its creation, the PNLS introduced a short-term emergency plan followed by two phases of medium-term plans (1989-1991; 1996-1998) financed by the WHO. In 1994, the first Centre de Traitement Ambulatoire (CTA) (Outpatients Treatment Centre) for AIDS in Africa was set up in Brazzaville.

From 1997, activities for the fight against AIDS fell back following the repeated wars which took place in the country. A second CTA (outpatients centre) was set up in Pointe-Noire in 1999.

According to the survey on seroprevalence performed by the Conseil National de Lutte contre le SIDA multisectoral committee in 2003, the rate of national prevalence was estimated at 4.2% with disparities from one town to another. The number of people infected with HIV in the Republic of Congo is estimated at 110,000.

The following table gives data on the UNGASS indicators selected by the Republic of Congo:

**Table 1: Data for each UNGASS indicator selected by the Congo.**

Indicators	Field	Measure/Data	Source
.GE: Indicator 3 – HIV/AIDS education based on skills taught at school	Prevention	5425 public school teachers were given training in HIV/AIDS.	PRESIEC report
.GE: Indicator 4 – Fight against HIV/AIDS at the workplace	Support environment.	20 companies have a policy and action plans for fighting against HIV/AIDS.	SEP/CNLS, PNUD, BIT.
.GE: Indicator 5 – Sexually transmissible infections: complete treatment of cases	Diagnosis and treatment of STIs	The percentage of men and women with STIs out of a total of 279, is 6.5 and 3.2, respectively.	ACBEF/Brazzaville
.GE: Indicator 6 – Prevention of TME: antiretroviral treatment	Prevention	The rate of TME without treatment is 30% against 6.3% after the administration of ARVs.	CTA
.GE: Indicator 7 – HIV treatment: combination of antiretrovirals	Treatment	The number of patients taking ARVs rose from 1900 in 2004 to 2550 in 2005.	ICAARV
.GE: Indicator 8 – Support for children suffering from HIV	Care and support	The total number of orphans who benefited from support is 3203, of which 45% were female.	SEP/CNLS
.GE: Indicator 9 – Transfusion safety	Prevention	100% of blood units transfused were screened for HIV.	CNTS
.GE: Indicator 10 – Young people's knowledge for prevention	Prevention	The number of young people with basic knowledge about HIV/AIDS varies from 80 to 90%	SEP/CNLS

.GE: Indicator 11- Sexual relations among under 15 years olds	Prevention	10% of young men and women have sexual relations before the age of 15.	SEP/CNLS
.GE: Indicator 12 – High risk sexual relations between young people	Prevention	The score for this indicator by sex and residence is 67.6 and 68.6 respectively.	SEP/CNLS
GE: Indicator 13 – Use of condoms by young people during sexual relations with occasional partners	Prevention	82% of young people claim to have used a condom during sexual relations with occasional partners.	SEP/CNLS
.GE: Indicator 14 – School attendance by orphaned children	Care and support	Data not available.	

.GE: Indicator 15 – Reduced prevalence of HIV	Prevention	4.08% of young people aged between 15 and 24 are infected with HIV.	SEP/CNLS
.GE: Indicator 16 – HIV treatment: survival after 12 months antiretroviral treatment	Data not available	A survey is planned for this year to provide data for this indicator.	
.GE: Indicator 17- Reduced transmission from mother to child	Prevention	4.5% of infants born of mothers infected with HIV are also infected with HIV.	CTA
.C/LPE indicator 3 – HIV screening among populations most at risk	Prevention	The percentage of each category of vulnerable groups who have had HIV screening and know the result is given below: Sex professionals: 3.3%  Transport personnel:17.3%  Male homosexuals: 8.3%.	SEP/CNLS
.C/LPE indicator 4 – Prevention programmes targeting the populations most at risk	Prevention	The percentage of each category of vulnerable groups attending HIV prevention programmes is given below:  Sex professionals: 42%  Transport personnel: 22% Male homosexuals: 41%	SEP/CNLS

.C/LPE indicator 5- Knowledge of HIV prevention shown by populations most at risk	Prevention	The percentage of each category of vulnerable groups with accurate knowledge of how to prevent the risk of sexual transmission of HIV and who reject the main false ideas concerning transmission of the virus is given below:  Sex professionals: 66.6%  Transport personnel: 4% Male homosexuals: 3.3%	SEP/CNLS
.C/LPE indicator 6 – Use of condoms by sex professionals	Prevention	78.5% of sex professionals said they used a condom with their last customer	SEP/CNLS
.C/LPE indicator 7 – Use of condoms by male homosexuals	Prevention	23% of male homosexuals said they use a condom	SEP/CNLS
.C/LPE indicator 9- Reduction in HIV prevalence in populations the most at risk	Prevention	Data not available at present because the national seroprevalence survey is planned for 2008.	

## II. Overview of the AIDS epidemic

According to data taken from the seroprevalence survey performed in November 2003, the average rate of prevalence of HIV on a national scale in adults aged 15 to 49 was estimated at 4.2%, with disparities from one town to the next.

The results of this survey show a general epidemic in the process of implosion.

**Table 2. Distribution of the prevalence of HIV/AIDS based on regional capitals in the Congo in 2003**

<b>Regions</b>	<b>Rate of prevalence</b>
1 - Brazzaville	3.3 %
2 - Pointe-Noire	5.0 %
3 – Dolisie	9.4 %
4 – Sibiti	10,3 %
5 – Madingou	4.7 %
6 – Nkayi	2.6 %
7 – Kinkala	2.6 %
8 – Djambala	1.3 %
9 – Owando	3.0 %
10 – Impfondo	1.3 %

The number of people infected with HIV in the Republic of Congo is estimated at 1 10,000

HIV prevalence is particularly high in the 35 to 39 (8.4%) and 40 to 44 (7.8%) year old age group. There is a tendency towards feminisation of the epidemic, with an average of 4.7% in women against 3.8% in men. An increase in the risk of seropositivity was observed with age, earlier in women than in men. This risk is at a maximum between the ages of 25 and 39 in women and between 35 and 49 in men. Before the age of 35, women are twice as likely to be infected as men.

The prevalence rate also varies with level of education: 5.4% of the uneducated, 4.1% for those with primary education, 4.8% for mid-school level, 3.0% for high school level and 2.5% for university level. The risk of seropositivity was significantly lower in those with a level of education reaching high school or more than in those with no education or not beyond mid-school level.

The seroprevalence of syphilis was estimated at 0.5%.

In 2006, it is planned to perform a Sentinel surveillance survey of HIV prevalence and behaviour, based on the most vulnerable groups, as well as a study of the effect of treatment on quality of life of people living with HIV, in order to measure the impact of current programmes.

### **III. National response to the AIDS epidemic**

#### **1. Institutional context of the response**

Since December 2002, the Republic of Congo has had a national strategic framework for fighting HIV/AIDS and STIs for 2003-2007.

This framework defines the strategies for the fight against HIV/AIDS and is based on six themes: (i) reinforcing prevention, (ii) improving treatment, (iii) reinforcing epidemiological monitoring, (iv) promoting research, (v) controlling sexually transmissible infections, (vi) reinforcing coordination and partnership.

In application of the strategy for fighting HIV/AIDS, the institutional framework has been reviewed and a National Council for the Fight against HIV/AIDS (SEP/CNLS), a multisectoral organisation for coordinating and directing the national response to HIV/AIDS set up. SEP/CNLS is headed by the President of the Republic. It has a central Permanent Executive Secretariat and regional units

for the fight against HIV/AIDS.

The Ministry of Health and twelve other ministries have set up "Unités de Lutte contre le SIDA" (ULS) (Units to Fight AIDS). These coordinate the sectoral response to HIV/AIDS and set up focal points in each region.

## **2. Prevention**

### **2.1. Prevention of sexual transmission**

Prevention actions are developed by the Units to fight AIDS (ULS) and civil partnerships. Information, education and communication (IEC) about HIV/AIDS is included in the minimum activity package (PMA) at integrated health centres (CSI). At the end of 2005, 14 CSIs included the IEC on HIV/AIDS and STIs in their activities.

Twelve (12) ULS other than health units are developing preventive actions based on social communication and education by ministries working with workers and vulnerable groups, according to their brief: prisoners for the ministry of justice, handicapped people for the ministry of social affairs, pupils and students for the information ministries, young people attending youth centres for the ministry of youth.

Civil partnerships are developing programmes targeting the most vulnerable groups as follows: sex professionals, male homosexuals, teenage mothers, uneducated or no longer educated young people, etc...

In 2005, 59 community projects were financed as part of the National AIDS Control Program financed by the World Bank. Initial evaluation of the effects/results

of these programmes is planned for the end of 2006.

## **2.2 Knowledge, attitudes and sexual practices.**

a) The percentage of 15 to 24 year olds who both correctly identify the means of preventing the sexual transmission of HIV and reject the main false ideas about HIV prevention, varies between 80 and 90%. 10% of young people have sexual relations before the age of 15. In terms of sexual relations with occasional partners, 82% of young people claim to use condoms during these sexual relations.

b) Data from the CAP survey of a sample of 365 people belonging to three categories of vulnerable groups, reveals that concerning knowledge of how to prevent HIV/AIDS, the proportion of sex professionals with good basic knowledge of HIV/AIDS is more than 10 times that of transport personnel and male homosexuals, 66.6% against 4% for transport personnel and 3% for male homosexuals.

c) In terms of access to prevention programmes, the proportion of sex professionals and male homosexuals is almost the same (42% and 41%, respectively) and higher than that of transport personnel (22%). Similarly, the rate of condom use in sex professionals (78.5%) is distinctly higher than that of male homosexuals and transport personnel, with 23% and 42%, respectively.

### **2.3. Prevention of mother-child transmission**

Since 2003, at Pointe-Noire and Brazzaville, the Congo has instigated a programme to prevent the transmission of HIV from mother to child. In the absence of treatment, the level of mother-child transmission was 30%. Since the PTME Programme was introduced in the Republic of Congo, this level has fallen from 30% to 6.5%.

### **2.4. Transfusion safety**

Transfusion safety is guaranteed in all medical institutions. In 2005, 27 000 units of safe blood were transfused. Over the past three years, 100% of blood units transfused have been systematically screened for HIV. Markers such as Hepatitis B and C and syphilis were also systematically tested for. Donors are mainly voluntary donors.

### **2.4. Voluntary advice and screening**

The Congo has two anonymous, voluntary screening centres in Brazzaville. These performed 5 093 voluntary screenings in 2005 and 788 were found to be positive (i.e. 15.4%). Outside Brazzaville, voluntary screening services are provided by the CTA and blood transfusion centres.

The results of the CAP survey of the most vulnerable groups including transport personnel (tax and bus drivers and inspectors), Male homosexuals and sex professionals revealed that voluntary screening levels are still low in these groups, with 3.3% of sex professionals, 17.3% of transport personnel and 8.3% in male homosexuals. These low percentages must be qualified because it was not possible to collect data

on the rate of frequentation of the CDAV (screening centres) by this category of the population.

## **2.5. Screening and diagnosis of sexually transmissible infections**

The data on sexually transmissible infections given in this report is taken from the Association Congolaise pour le Bien-Être Familial (Congolese association of family well-being) which has a centre for complete treatment of STIs, which meets UNGASS criteria. In 2005, 279 patients suffering from ISTs were given full treatment there. Analysis of the data reveals that the proportion of women with STIs was higher than that of men, with 6.5% and 3.2%, respectively. A survey of health centres treating STIs is planned to combine STI data for the Congo.

## **3. Treatment**

Within the framework of global treatment of people living with HIV, the Congo has two outpatient treatment centres, one at Pointe-Noire and the other in Brazzaville. These centres are the main structures providing global treatment for people living in the country. The active list of HIV-positive patients in these two centres in December 2005 numbered 3 478, of which 1 230 were under antiretroviral drugs.

The total number of patients taking ARVs in the Congo rose from 850 in 2003 to 1900 in 2004 and 2550 in 2005, giving an increase in recruitment rate of 33% over the past three years. At the end of 2004, the regular monitoring of patients taking ARVs was 88%, the percentage lost to follow-up was estimated at 10% and the specific mortality rate at 3%.

No information was available on the proportion of patients with opportunistic infections.

#### **4. Epidemiological surveillance**

Epidemiological surveillance of HIV/AIDS is still first generation and concerns pregnant women only. The data for epidemiological surveillance of HIV in pregnant women in 2005 has not been validated.

#### **5. Orphans and other vulnerable children (OVC)**

The operational definition of OVCs in the Congo is not limited to children who have lost one or two parents to HIV/AIDS infections. It encompasses not only children orphaned by AIDS but by other causes also. The data given in this report takes this operational definition into account.

In all 3203 orphans, 45% of whom were girls, were provided with support by the OVC component of the SEP/SEP/CNLS. Further details on indicator 8 relative to OVCs can be obtained from the CRIS file enclosed with the report.

#### **6. Private sector response**

Workshops supporting the drafting of policies and action plans to fight HIV/AIDS in the workplace were organised in 2005 by the SEP/CNLS, in partnership with the PNUD, BIT and UNICONGO. At the end of these workshops, 20 companies had adopted policies and action plans to fight against HIV/AIDS. The policy document for each company describes the principles which employer and employees are required to respect with regard to people living with HIV. Principles such as non-discrimination, forbidding mandatory screening and promoting voluntary screening are included in the policies defined by 20 companies. The action plans drafted by these companies take into account the main strategic themes such as prevention and treatment for employees infected with HIV.

## **7. Others**

Information on the composite index of national policies is included in a file enclosed with this report.

## **IV. Main obstacles encountered and action needed to achieve UNGASS aims/objectives**

### **1. Obstacles**

The main obstacles encountered preventing full achievement of UNGASS aims/objectives are as follows:

- a) Weakness of a functional health information system ;
- b) Weakness of the system for epidemiological surveillance of HIV/AIDS;
- c) Lack of training for data managers in the use of CRIS and other software such as Stata and SPSS.
- d) Inadequate resources allocated to the fight against HIV/AIDS: the Government contributed 33 million CFA to the fight against HIV/AIDS in 2003; this only began to increase gradually from 2004 with the implementation of the programme for access to antiretroviral drugs. This contribution was 505 million CFA in 2004 and about 2,500,000,000 CFA in 2005. The biggest contribution from partners in the fight against HIV/AIDS was the World Bank donation of 19 million USD, but this was only available at the end of 2004. It did not provide national cover of actions to fight HIV/AIDS however, but was concentrated in the regions with the highest prevalence of HIV.

- e) Before 2004 there were no reference tools for training and no provision of the various essential activities in prevention or the treatment of people living with HIV.

## **2. Measures to take.**

The following measures are envisaged to achieve UNGASS objectives:

- a) Reinforce the health information system with the support of the Health Metric Network;
- b) Implement a second generation system of epidemiological surveillance focused on the most vulnerable groups.
- c) Organise sessions to train data managers in the use of CRIS software, with the support of the regional ONUSIDA (UNAIDS) team for West and Central Africa.
- d) Organise sessions to train data managers in the use of Stata and SPSS software;
- e) Effective mobilisation of extra funds destined for the fight against HIV/AIDS with the Global Fund to Fight Aids, Tuberculosis and Malaria, with the aim of: (i) covering all the most vulnerable populations in the country, (ii) managing the transition to the scale of global treatment programmes for people living with HIV, treatment of sexually transmissible infections and preventing the transmission of HIV from mother to child.
- f) Reinforce coordination with: (i) regular operations by the national and regional representatives of the SEP/CNLS; (ii) implement mechanisms for

agreement between all the national, bilateral and multilateral partners with the aim of monitoring and harmonising the different operational methods used.

## **V. Necessary support from development partners in the country**

To achieve UNGASS objectives, the Congo needs the support of its partners. This support is based on:

- mobilising resources with the Global Fund to Fight AIDS, Tuberculosis and Malaria;
- respecting the principles of the "Three ones" in the support provided for the country, in order to guarantee complementarity and synergy of the national response to HIV/AIDS;
- support in reinforcing the country's human resource capacities;
- support in installing effective monitoring and evaluation systems.

## **VI. Framework for monitoring and evaluation**

Within the SEP/CNLS Permanent Executive Secretariat, there is a functional monitoring and evaluation unit. After a long participatory process, this unit has developed a monitoring and evaluation manual, validated by all the key partners involved in the fight against HIV/AIDS. This manual describes (i) the list of national and international indicators to be supplied quarterly or annually, (ii) the circuit for collection and transmission of peripheral data to the centre and vice-versa.

A national monitoring and evaluation plan for the national response to HIV/AIDS will be drawn up this year. It will guarantee:

- the availability of data on implementation of the programmes;
- Their impact on population vulnerability to HIV;
- Their impact on the quality of life of people living with HIV.

The ability of Congo executives to use CRIS software in the monitoring and evaluation field must be improved.

The Congo needs technical assistance in performing a national seroprevalence survey in 2008 and evaluating the effect of the programmes implemented since 2003.