



Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa REPORT

**Maseru, Lesotho
10-12 May 2006**

**STEP UP THE PACE
OF HIV PREVENTION
IN AFRICA**



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List of Abbreviations

ABC	Abstain, be faithful, use condoms
ANC	Antenatal clinic
ART	Antiretroviral therapy
ARV	Antiretroviral
CBOs	Community-based organisations
CSOs	Civil society organisations
C&T	Counseling and testing
EP	Exposure prophylaxis
FBOs	Faith-based organizations
GBV	Gender-based violence
(HSV-2)	Herpes simplex virus-2
HIV	Human immunodeficiency virus
ICPs	International Collaborating Partners
MC	Male circumcision
M&E	Monitoring and evaluation
MoH	Ministry of Health
NACs	National AIDS Councils
NGOs	Non-governmental organisations
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
RCT	Randomised controlled trial
RNE	Royal Netherlands Embassy
SADC	Southern African Development Community
Sida	Swedish International Development Cooperation Agency
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Childrens Fund
USAID	United States Agency for International Development
WHO	World Health Organization
VCT	Voluntary counseling and testing



Table of Contents

Abbreviations	i
Foreword	2
Executive Summary	3
1. Background	4
Purpose of the Meeting	4
Overview of the Meeting Programme	4
2. Review of the evidence around HIV prevention in mainland southern Africa	5
The drivers of the epidemic in mainland southern Africa	5
Prevention works: Evidence from Kenya, Uganda and Zimbabwe	5
3. Review of the evidence of the technical interventions to prevent HIV	6
Abstinence	6
Faithfulness	6
Condom Use	6
Male Circumcision	6
Intergenerational - Age Disparate Sex	6
Sexual Violence	6
Voluntary Counselling and Testing (VCT)	7
Sexually Transmitted Infections	7
Microbicides	7
Discordant Couples	7
4. Recommendations:	8
Key Priorities and Processes	8
Recommended Key Processes	8
Recommendations for National AIDS Councils	9
Recommendations for SADC and the International Cooperating Partners	9
Recommendations on Monitoring and Resources	10
Annex 1: Summary of evidence base of interventions for HIV prevention	11
Annex 2: Participant List	13
Annex 3: Meeting Agenda	15
Annex 4: Acknowledgement of reproduction permission from journals	17
Annex 5: CD Contents	18

The presentations and peer reviewed articles from leading international journals that formed the basis of the discussion at the SADC Experts Think Tank Meeting is included on the CD-Rom, which is enclosed at the back of this report.

Sub-Saharan Africa and the SADC region in particular carry the heaviest burden of HIV and AIDS in the world. It is estimated that by the end of 2005, the average adult prevalence of the SADC region was about 11 percent as opposed to the global figure of 1 percent. The SADC region with 4 percent of the global population is home to about 40 percent of people living with HIV and AIDS in the world. The SADC region continues to have a large share of new HIV infections, in 2005, 1.5 million new cases were estimated, representing about 37 percent of global new infections.

The scale of the epidemic makes HIV and AIDS the single greatest threat to attaining SADC's over-arching objective of sustainable and equitable economic growth and socio-economic development that will ensure poverty alleviation and ultimately its eradication. The epidemic if unabated will continue to erode the hard won gains and intensify poverty and human suffering. Similarly, the level of the epidemic makes the attainment of many of the globally agreed Millennium Development Goals difficult.

The continued high levels of HIV prevalence and the limited successes in turning the tide of the epidemic in the region resulted in the calling of a Special Summit on HIV and AIDS by SADC Heads of State and Government in Maseru, in 2003. One of the outcomes of the Summit was the Declaration on HIV and AIDS commonly referred to as the Maseru Declaration. This Declaration provides the highest political commitment on HIV and AIDS in the region and articulates priority areas requiring urgent attention and action in various areas including prevention.

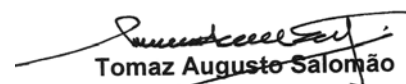
The prioritization of prevention was further given impetus by the Maputo Declaration of August 2005. This Declaration adopted by 46 African Health Ministers at a WHO meeting held in Mozambique, resolved to accelerate HIV prevention and declared 2006 as the Year of Acceleration of HIV Prevention in the African Region. The prevention agenda was further highlighted in the Brazzaville Commitment on Universal Access Initiative adopted on March 6, 2006 by the African Union, UNAIDS and WHO. This initiative aims to ensure Universal Access to prevention, care and support and treatment by 2010.

It was against this background that the SADC Secretariat with the support of the International Cooperating Partners organized an Experts Think Tank Meeting on HIV Prevention in Maseru, to reflect on the key drivers of the epidemic in the region and to provide suggestions for accelerating HIV prevention. This report is an outcome of



the Experts Think Tank Meeting which was attended by experts from the National AIDS Commissions, Research Institutions, NGO's and International Cooperating Partners.

This report should therefore serve as an important input to various SADC structures as we strive for evidence-based policy proposals and interventions. The report is meant to contribute to the continuous policy discourse on accelerating HIV prevention in the region.



Tomaz Augusto Salomão

Executive Secretary
SADC Secretariat



Executive Summary

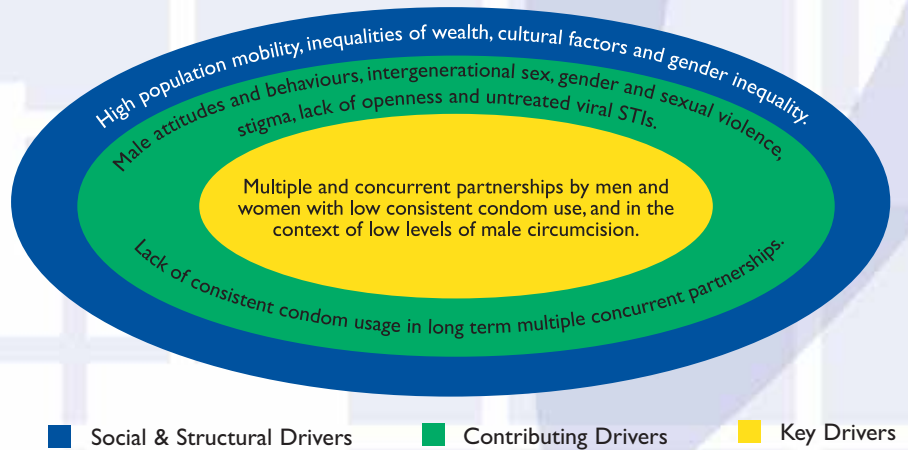
The Southern African Development Community (SADC) is at the epicenter of the global HIV epidemic. According to the latest estimates by UNAIDS the average adult HIV prevalence rate in this sub-region is about 11 percent compared to one percent globally. It is estimated that approximately 40 percent of all people living with HIV globally are living in the SADC region and approximately 37 percent of all new infections in 2005 occurred in this region.

Concerned by the continuing increase in the epidemic and in support of the Year for Accelerating Access to HIV Prevention, the Secretariat of the Southern African Development Community (SADC), with the support of the Regional HIV Prevention Group comprising UNAIDS, UNFPA, WHO, UNICEF, Sida and USAID, convened a *three-day Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa*.

The meeting was attended by 38 participants comprising representatives from National AIDS Councils, HIV prevention focal points, leading prevention experts, the SADC Secretariat, the United Nations, Sida, USAID, research institutions and non-governmental organisations. The meeting participants analysed the evidence on the drivers of the epidemic in the sub-region focusing specifically on sexual transmission of HIV and made proposals to accelerate prevention efforts over the coming year to two years.

Key drivers of the epidemic in southern Africa identified by the participants included multiple concurrent partnerships by men and women with low consistent condom use, and in the context of low levels of male circumcision. Male attitudes and behaviours, intergenerational sex, gender and sexual violence, stigma, lack of openness, untreated viral STIs and lack of consistent condom usage in long-term multiple and concurrent partnerships were identified as significant contributing drivers of the epidemic. Underlying these drivers are the social and structural factors such as high population mobility, inequalities of wealth, cultural factors and gender inequality that render young women especially vulnerable to HIV infection.

Figure 1: Drivers of the HIV Epidemic in SADC



The meeting participants concluded that amongst other recommendations, priority should be given to interventions that aim to:

- Reduce the number of multiple and concurrent partnerships;
- Prepare for the possible roll out of male circumcision;
- Address male involvement and responsibility for sexual and reproductive health, HIV prevention and support;
- Increase consistent and correct condom use; and
- Continue programming around delayed sexual debut in the context of condom programming and reduced partnerships.

The meeting participants also recommended that the National AIDS Councils undertake national reviews of the evidence regarding HIV prevention, the drivers of the epidemic, policies, programmes and work plans, taking into account the evidence emerging from the SADC Expert Think Tank Meeting.

The participants recommended that SADC and the International Cooperating Partners continue to undertake advocacy efforts on changing behaviour and social norms targeting leaders within the region; support countries in undertaking their national consultative process on HIV prevention; facilitate a review of the evidence and research regarding behaviour change, social norms, male circumcision, counseling and testing; and strengthen monitoring and evaluation.

The presentations and peer reviewed articles from leading international journals that formed the basis of the discussion at the SADC Experts Think Tank Meeting are included on the CD-Rom, which is enclosed at the back of this report.

1. Background

The HIV epidemic continues unabated in sub-Saharan Africa. Across the continent there are highly diverse epidemics and southern Africa remains the epicenter of the global HIV and AIDS epidemic. Average adult HIV prevalence (15-49 years) in the 14 Member States of SADC was estimated at 10.8 percent in 2005 as opposed to 6.1 percent for the continent and one percent globally.

In some countries of the region adult HIV prevalence rates continue to increase, while in others they appear to have stabilized. This perceived stabilization is due to changes in incidence and rising numbers of AIDS-related deaths and continuing high HIV incidence offsetting this mortality. Kenya, Uganda and Zimbabwe have all recorded recent declines in adult HIV prevalence, linked with investments made in prevention interventions as well as increased deaths.

It is estimated that of the 38,6 (33,4 - 46,0) million people living with HIV globally, close to 15 million are in the SADC sub-region representing 38 percent of the total number of people living with HIV globally. There is also no evidence, with the exception of Zimbabwe, that HIV prevalence is decreasing in the sub-region. In 2005 there were 1,5 (1,3 - 1,7) million new HIV infections in the SADC region representing more than 36.5 percent of all new infections globally. The main mode of HIV transmission in sub-Saharan Africa is heterosexual sex.

Concerned about the continuing high number of new infections and prevalence of HIV in mainland southern Africa, the Secretariat of the Southern African Development Community (SADC) requested UNAIDS to organise a three-day Expert Think Tank Meeting to review the evidence around HIV prevention in that sub-region. The meeting also took place in support of the 55th Council of Ministers Meeting held in Maputo, Mozambique, in August 2005, during which African health ministers declared 2006 as the Year for Accelerating Access to HIV Prevention in Africa.

The SADC Expert Think Tank Meeting was organized under the auspices of the regional HIV Prevention Group bringing together the collective efforts of UNAIDS, UNFPA, WHO, UNICEF, Sida and USAID in conjunction with the SADC Secretariat.

Purpose of the Meeting

The purpose of the meeting was to analyse the evidence on drivers of the epidemic in the sub-region focusing specifically on sexual transmission of HIV, with a view to



making proposals for exceptional actions to accelerate prevention of HIV from sexual transmission within the coming year or two years.

The aim was to clarify where to build on existing approaches, to recommend how to do things differently, to agree on what to scale up and to identify the gaps and limitations in current responses.

Overview of the Meeting Programme

The programme of the meeting was structured into plenary sessions comprising expert presentations on different thematic areas and countries, brainstorming on what could have been done differently over the past fifteen years and what should be prioritized now and group discussions. The following is a brief outline of the main topics addressed:

- Review of the epidemiological and behavioural surveillance evidence from southern Africa;
- A review of the key facts in incidence decline drawing on the experiences of Kenya, Uganda and Zimbabwe;
- An analysis of behaviours and social norms driving the epidemic in the sub-region; and
- A review of the evidence around the impact of services for HIV prevention in southern Africa.

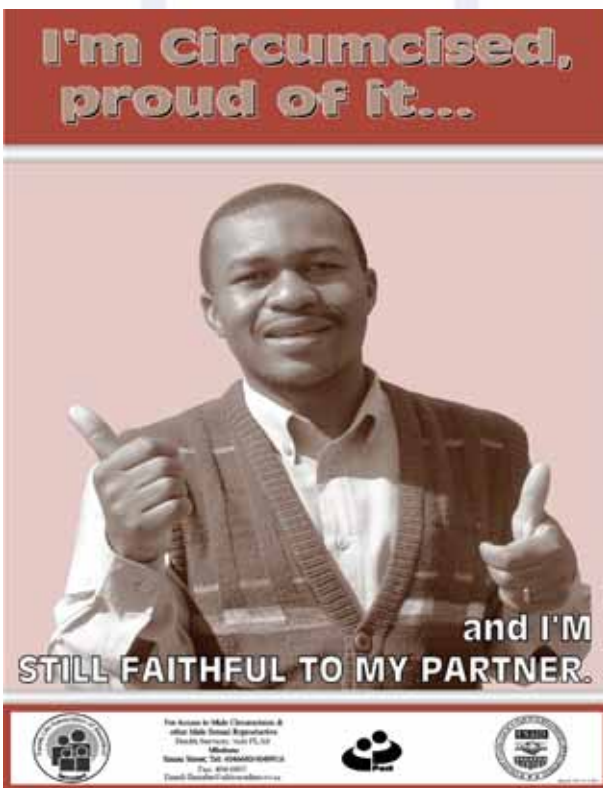


2. Review of the evidence around HIV prevention in mainland southern Africa

An overview was provided of the latest information on HIV prevalence and trends in mainland southern Africa. The overview included a review of behavioural surveillance and an examination of the lessons that could be learnt from the three African countries where HIV prevalence has declined, namely: Kenya, Uganda and Zimbabwe.

The drivers of the epidemic in mainland southern Africa

The meeting concluded that high levels of multiple and concurrent sexual partnerships by men and women with insufficient consistent, correct condom use, combined with low levels of male circumcision are the key drivers of the epidemic in the sub-region.



FLAS Swaziland

Contributing drivers fuelling the epidemic include male attitudes and behaviours, in particular intergenerational sex or age differential over 5 years, gender and sexual violence, stigma, lack of openness about the epidemic, untreated viral sexually transmitted infections (STIs), and lack of consistent condom usage in long-term multiple concurrent partnerships. Underlying these biological and social drivers are the structural factors of high mobility, inequalities of wealth and some cultural factors including gender inequality, with young women rendered particularly vulnerable to HIV infection.

Prevention works: Evidence from Kenya, Uganda and Zimbabwe

In Uganda, Kenya and Zimbabwe, reduction in multiple sexual partners was the most extensive contributing factor for HIV incidence decline.

In Uganda delayed sexual debut contributed to delayed HIV infection and greatly reduced incidence amongst adolescents, but had little clear sustained impact as people entered their twenties. More recently the increased usage of condoms probably contributed to a further reduction in incidence. This was brought about through comprehensive and mutually reinforcing communication messages of “zero grazing”, fear (both from messaging and from witnessing ill-health and death), top-level political leadership and a groundswell of community involvement and ownership. Community engagement was also high in Kenya and Zimbabwe.

In Kenya, delayed sexual debut and increased condom uptake occurred that contributed to the decline in HIV, but were less significant than partner reduction.

In Zimbabwe, high condom use was a significant factor, as well as partner reduction, but age at sexual debut, already high, did not change.

In the sub-region overall, rates of bacterial STIs are declining, but rates of viral STIs remain high. There is limited evidence of the impact at population level of interventions such as voluntary counseling and testing (VCT), STI treatment, peer education, and women’s empowerment. Mass media and comprehensive sexuality education are considered to have been influential in changing social norms and behaviours among young people.



3. Review of the evidence of the technical interventions to prevent HIV

The following is an overview of the evidence presented to the meeting on the impact of HIV prevention interventions designed to reduce the number of new infections through heterosexual transmission.

Abstinence

Interventions have contributed to later sexual debut in some countries (e.g., by two years in Uganda). There is, however, evidence of faster rates of HIV acquisition by previously abstinent young people during their 20s (a “catch-up” phenomenon), as documented in Uganda.

Faithfulness

Multiple and concurrent partnerships, comprising complex and inclusive sexual networks, are a key driver of the epidemic in the region owing to the high risk of HIV transmission during the acute stage of HIV infection (incident infection). A study in Malawi found that in seven villages 65 percent of sexually active adults were linked in one sexual network.

Unprotected sex in or between population groups such as migrant workers, sex workers, and uniformed forces, who generally have higher than average HIV prevalence, is no longer a core epidemic driver in these generalized epidemics and accounts for a relatively small proportion of new infections. This is because of relatively high consistent correct condom use in these high-risk sexual encounters, and the numbers of people involved are relatively low compared to the general population within which most transmission now takes place (and where condom use is lower).

Condom Use

Condoms are 80-90 percent effective at preventing HIV when used consistently and correctly. However, it is difficult to achieve widespread consistent and correct usage, particularly in marriage and stable partnerships. In highly generalized epidemics, where longer-term concurrent partnerships are widespread, the impact of condom programming may have an insufficient impact on preventing new HIV infection, even though maintaining condom use in these relationships remains essential for individual protection.

Additional results of condom programming may be either reduced or increased partner numbers.

UNAIDS estimates that there is only 19 percent male condom coverage in sub-Saharan Africa, illustrating the need for condoms to be scaled up and to ensure a regular

supply so as to avoid stock-outs. Female condoms have not been adequately programmed and scaled up to date, but they are very important as a female-controlled method.

Male Circumcision

The Orange Farm randomised, controlled trial (RCT) in South Africa was stopped early on the finding that male circumcision has a 60 to 75 percent protective impact. It confirmed extensive observational studies of discordant couples, population-level correlations, cross-sectional surveys and other research that showed the preventative benefits of male circumcision to be in the region of 50-75%, at least as high as that likely to be achieved by a vaccine or microbicide.

There is compelling evidence that male circumcision in itself is protective, but the population impact of rolling out male circumcision at national level is not yet known.

In generalized epidemics, any products that need consistent use by the majority tend to be problematic; and, interventions that have lower efficacy but very high uptake in the general population are likely to be more effective at reducing incidence. This is a core advantage of male circumcision if it is performed on large numbers of males, as it is a one-off intervention conferring lifelong reduced biological risk. Circumcised males and their partners still need to reduce the number of partners and to use condoms consistently and correctly, in any sexual relationship outside mutually faithful relationships between HIV-negative partners.

Intergenerational – Age Disparate Sex

Higher HIV prevalence in young women correlates with sexual relationships with older male partners. Intergenerational/age disparate sexual relationships are common, but few studies and interventions focus on the men involved, or analyse the risk determinants for age and socio-economic inequality in relationships. Stereotypical affluent “sugar daddies” are only part of the picture, and poorer men play a larger role than often recognised. Young women often have few other opportunities than these transactional relationships for survival or to gain a range of benefits.

Sexual Violence

Studies are not available to date to show a direct correlation that reducing sexual violence reduces HIV infection risk. There are indications, however, that survivors of sexual violence are likely to engage in higher risk sexual

activities (e.g., anal sex, age difference, money for sex, group sex) and thereby be at greater risk of HIV infection as well as from violent sex itself.

Sexual violence is linked with a culture of violence involving negative attitudes (e.g., deliberate intention to spread HIV) and reduced capacity to make positive decisions or to respond appropriately to HIV prevention campaigns.

Studies of male and female school students in several southern African countries found 7-17 percent reported forced sex in the previous year, and 30 percent reported forced sex by age 18. Survivors were more likely to become perpetrators of sexual violence themselves, even as young people. Therefore, addressing sexual violence could contribute to HIV reduction (as well as being an essential human rights concern).

Voluntary Counseling and Testing (VCT)

The impact of counseling and testing on behaviour change does not appear strong or consistent, although those testing HIV positive are more likely to change their behaviour than HIV-negative clients. A systematic review of voluntary counseling and testing (VCT) at 18 sites, including eight antenatal clinics (ANC) and seven free-standing services, is inconclusive on the use of VCT as a preventative intervention (except for prevention of mother-to-child transmission (PMTCT), and VCT services should be reoriented to be more effective for HIV prevention.

Evidence from Kenya suggests that VCT led to an increase in condom usage in discordant couples and with non-primary partners, but not with primary partners.

In Uganda, community VCT did not reduce risky behaviours by participants that were HIV negative or HIV incidence. In Zimbabwe, a workplace VCT programme had no measured impact on HIV or STI incidence.

Further research is required to determine the impacts of different approaches to counseling and testing, including VCT in different settings and provider-initiated services. So far the evidence regarding the use of VCT as a preventative intervention does not appear high. However, VCT has important benefits as an entry point for care and treatment, PMTCT, increased openness and reduced stigma.



Sexually Transmitted Infections

The situation is highly complex, and each country needs to develop strategies according to the prevailing patterns of STIs within the population.

Treatment of bacterial STIs (as in syndromic management) reaches relatively few people and is not sufficient to have a significant impact on HIV prevention. In southern Africa, the majority of STIs are viral, not bacterial, and hence syndromic treatment has no impact on the majority of STIs. Efforts to prevent and control STIs have far greater potential impact on HIV prevention at the population level, requiring the same or similar interventions as HIV prevention.

Evidence suggests that individuals with herpes simplex virus-2 (HSV-2) have increased risk of acquiring HIV and of transmitting HIV to others, and randomised, controlled trials are underway to investigate the impact of HSV-2 preventative and suppressive therapy on HIV acquisition and transmission.

Microbicides

The meeting concluded that microbicides are a promising prevention intervention for the future, but they are highly unlikely to be widely available before 2010.

Discordant Couples

In Uganda, 30-50 percent of couples tested for HIV are discordant, yet only 12 percent of those starting antiretroviral therapy (ART) knew that discordance was possible and less than 50 percent of these couples reported consistent condom use. This illustrates the need for prevention efforts to increasingly target discordant couples through “positive prevention” initiatives, particularly consistent, correct condom use.



4. Recommendations

One of the key priorities of the meeting was to make recommendations based on an analysis of the evidence of interventions that can be made available rapidly or scaled-up to accelerate access to HIV prevention. The recommendations included approaches and actions that National AIDS Councils (NACs), the SADC Secretariat and the International Cooperating Partners (ICPs) could undertake for increased impact on HIV prevention and to define areas for further strengthening and research.

Key Priorities and Processes

1. Significantly *reduce multiple and concurrent sexual partnerships* for both men and women. Explore possibilities for mass campaigns or social movements with strong political, religious and community leadership (both top down and bottom up) and endorsed by the mass media to expose and discourage multiple partnerships as a threat to individual and public health.
2. Prepare for the potential national roll out of *male circumcision* through acceptability, feasibility and costing studies depending on the readiness of individual countries, and/or on the outcome of the Kenya and Uganda RCTs of male circumcision. Male circumcision should be embedded within a broader context of strengthening male sexual and reproductive health (SRH), STI treatment, condom use, counseling and testing for HIV.
3. Address gender issues especially from the perspective of *male involvement and responsibility* for sexual and reproductive health, HIV prevention and support, and specifically to reduce multiple and concurrent partnerships, intergenerational/age disparate sex and sexual violence through multiple channels, including those noted for (1) above.
4. Continue to programme for *delayed sexual debut* and for *consistent and correct use of male and female condoms*, especially in higher risk situations, and for young people.

In addition to and in support of the above core areas of focus:

5. Increase access to *counseling and testing*, with an emphasis on national “know your status” campaigns backed by post-test services for both HIV-negative and people living with HIV, and linked with care and treatment.
6. Expand access/aim at *universal access to sexual and reproductive health services and to care and treatment*, with a special focus on expanding youth-friendly services.



UNAIDS/G. Pirozzi

7. Challenge the underlying structural drivers of the epidemic or risk environments, notably the complex interaction of poverty, socio-economic inequality and wealth, mobility, etc., to build more cohesive societies and also to challenge risky cultural practices and unequal gender norms.
8. Intensify multiple approaches, including involvement of people living with HIV and the media, to reduce stigma and increase openness and discussion, including of sexuality, and to uphold human rights.
9. Emphasise *STI control and prevention* while expanding and making treatment more effective, including with respect to HSV-2.

Recommended key processes:

1. Strong *grounding of responses in communities*, with the support of effective and committed leadership at all levels. *Committed and well-informed national-level leadership* must influence district and local leadership to promote effective local ownership and responses, and increased funding and resources should reach the local level to support community action. Included should be local level monitoring systems to enable local communities and leaders to measure the success of their own prevention efforts in reducing HIV prevalence and incidence.
2. Investment in *capacity building at all levels* for HIV prevention, especially through civil society including faith-based organisations (FBOs), community-based organisations (CBOs), non-governmental organisations (NGOs) and community leaders, and through the public, private and traditional health systems.
3. The greater and more effective *involvement of people living with HIV and AIDS*, particularly for “positive HIV prevention”.

Recommendations for National AIDS Councils

The NAC representatives agreed they should review national policies, programmes and work plans to align them with the outcomes of the meeting, and also in relation to the Brazzaville Commitment, the Abuja, Maputo and Maseru Declarations. They agreed that countries should validate nationally the key drivers of the epidemic, and they made the following recommendations for Member States to:

1. Carry out *behavioural studies* to establish the drivers of the epidemic.
2. Hold *national 'Think Tank' meetings* to identify priority actions, national prevention strategies, and to integrate meeting outcomes into work plans.
3. Hold *national consultations on male circumcision* as and when ready.
4. *Empower community leadership* for active involvement in HIV prevention.
5. Seek to *strengthen the technical capacity of HIV prevention specialists*.
6. Strongly promote *active participation of PLHIV*.
7. *Strengthen the coordinating bodies (NACs) on HIV programming and partnership*.

Support was requested from the *SADC Secretariat* to facilitate the harmonization of national HIV and AIDS strategic plans including on HIV prevention; to strengthen the capacity of prevention experts and of networking within SADC; to accelerate the establishment of a regional resource centre; to develop a database of resource persons and institutions for HIV prevention in the region; and, to support the sharing of emerging information on HIV prevention among the Member States.

Countries requested that the *International Cooperating Partners* respect and support the "Three Ones" principles (One Action Framework for Coordination; One National Coordinating Authority with a multisectoral mandate; and, One Country-level Monitoring and Evaluation (M&E) System); national and regional activities including operational research, campaigns and policy reviews and to harmonise national funding through a common basket.

Recommendations for SADC and the International Cooperating Partners

Regional-level actions must support the development, accelerated implementation and effective monitoring and

evaluation of national, evidence-based HIV prevention strategies that effectively target the key drivers of the epidemic.

1. *Advocacy and leadership engagement to change behaviour and social norms:*

- a. Arrange a briefing for SADC senior leadership, the Integrated Committee of Ministers, NAC directors, SADC Parliamentary Forum, and others on HIV prevention, emphasizing the evidence of epidemic drivers, the impact of interventions, experience and challenges.
- b. Arrange a media briefing (Southern Africa Editors Forum) on HIV prevention, including the development of media education and investigative programmes.
- c. Convene a meeting of faith leaders on HIV prevention progress and challenges, and mobilize an alliance of FBOs for sexual behaviour and social norms change.

2. *Technical and programming support for countries to change behaviours and social norms to support HIV prevention with the main focus on partner reduction:*

- a. Explore the possibility of forming a regional support team drawn from UN, NGO and partner organizations.
- b. Skills building for country level programming. Identify a regional-level institution to provide capacity-building support; consider arranging regional-level training.
- c. Compile and disseminate programming tools, materials and best-practice experiences.
- d. Establish/develop a database of available technical assistance.
- e. Provide guidance on key indicators and methods for M&E strategies to change behaviours and social norms in support of HIV prevention and emphasizing partner reduction.

3. *Support continued learning and experience exchange of national actors (government, NGOs, FBOs, CSOs, ICPs) involved in HIV prevention programmes:*

- a. Establish or identify a clearing house/repository for information materials related to changing social norms and behaviour for HIV prevention.
- b. Support countries to undertake national consultations on strategic, evidence-based HIV prevention.
- c. Consider a regional-level meeting for government/partners on HIV prevention experience exchange.

4. *Evidence review and research for changing behaviours and social norms:*

- a. Conduct a systematic review of research and experience (what has worked and what has not), with particular emphasis on partner reduction.
- b. Define the research agenda to inform the development of more effective change strategies focused on partnership reduction (include issues of male involvement, gender-based violence (GBV), intergenerational sex, etc.).

5. *Male circumcision preparedness (UNAIDS/WHO):*

- a. Disseminate male circumcision information packs to all NACs and MoH.
- b. Facilitate country- (5 countries) and regional-level stakeholder consultations on male circumcision.
- c. Form a regional-level working group to advise, oversee and support the implementation of a male circumcision preparedness work plan (i.e., incorporate SADC, NAC, MoH and key support agencies: WHO, UNFPA, UNICEF, UNAIDS).

6. *Counseling and testing (UNAIDS/WHO):*

- a. Document experience and lessons learned of “know your status” campaigns currently planned or under implementation in at least Lesotho, Botswana, Malawi.
- b. Conduct a review of country experience (progress, experience, lessons learned) in implementing the 2004 WHO/UNAIDS HIV counseling and testing policy.
- c. Convene a regional Counseling and Testing meeting to present, exchange and review/discuss experience in implementing the 2004 policy (recommended by the 2004 meeting and of considerable interest to WHO, Member States and other organisations).

Recommendations on Monitoring and Resources:

1. *Countries need to strengthen their M&E*, expanding research on the impacts of specific activities and programmes on behavioural drivers of the epidemic.
2. *More “user friendly” information systems are needed* that allow local communities actively to monitor the dynamics of the epidemic in ways that are meaningful and relevant to them.
3. *Regional policy-oriented research capacity needs strengthening and research networks developed/strengthened* among countries and institutions.
4. *Expand research methodologies*, including operational research, RCTs, etc., and draw on existing experiences and methods.
5. *Discussion is needed on locally conceptualized and standardized indicators.*
6. *Research and review legislation and policy on sexual violence.*



Annex 1: Summary of evidence base interventions for HIV prevention

Focus	Impact at population level	Impact at individual level	Recommendations or comments from the meeting	Comments
Abstinence	Temporary impact on young people through delayed debut, but tendency to have more rapid HIV acquisition in their 20s: e.g. "catch up" observed in Uganda; less relevance for adults.	While observed, 100 percent effective.	Continue efforts for primary abstinence for young people in conjunction with condom programming and reduced numbers of sexual partners.	"ABC" formulation has considerable baggage and has had less relevance for women. However, all three prongs are relevant and need reformulating for greater complementarity; avoid either/or formulation.
Be faithful	Appears to have been key to reduced incidence and prevalence in Uganda, Kenya and Zimbabwe.	100 percent effective IF fully maintained by two HIV-negative people (or in a polygamous union).	Make partner reduction the cornerstone of HIV prevention efforts in these generalized epidemics.	Concurrent relationships appear to be a key epidemic driver because of very high infectivity in acute/incident infection.
Condoms, male	Condoms are key in casual and commercial sex, but consistent use in longer-term relationships remains low. In generalized epidemics, longer-term relations account for a major share of HIV infections. Therefore increased condom use with non-regular partners has not consistently translated into HIV declines in high-prevalence countries, but contributed significantly to the decline in Zimbabwe and probably to the later decline in Uganda.	At least 80-90 percent protective if consistently and correctly used: the most protective device currently available for individual protection.	Continue to programme and scale up provision, ensuring consistent access.	Challenge is to achieve correct and consistent use (over 80%). Easiest in commercial sex, then casual sex, least in more stable partnerships, concurrent or not.
Condoms, female	Contribute to number of protected sex acts where available.	Highly protective against HIV, STIs and pregnancy.	Scale up, current numbers far too low.	Advantage of female use.
STI treatment alone (syndromic)	Limited impact on HIV prevention because only targets symptomatic STIs, and misses 50 percent of those needing treatment (asymptomatic) and fails to treat viral STIs.	Untreated STIs greatly increase HIV transmission risk, more so if ulcerous.	Essential in its own right.	Services only reach small proportion of infected individuals; increasingly in southern Africa viral STIs predominate, not bacterial, and treatment misses these.
STI control & prevention	More impact in concentrated than generalized epidemics, but crucial for young people in generalized epidemics.	As above.	Similar recommendations as for HIV prevention; use STI services as an entry point to identify acute HIV infection; link HIV and STI services.	Greater potential to reach large numbers, especially important for young people.
HSV-2	Recent infection with HSV-2 doubles the risk of HIV transmission, with recent infection with HSV-2 more risky than chronic infection.	HSV-2 treatment reduces HIV shedding and thus reduces infectivity.	Potentially an important contribution to HIV prevention, needs research results to assess impact.	Research is underway into HSV-2 control interventions (episodic and suppressive).
Male circumcision	Strong observational data of protective impact at population level; includes correlation with lower incidence and prevalence of HIV in African and other populations; one randomised, controlled trial (RCT) complete; two (Kenya and Uganda) underway as more evidence is needed on impact.	50-75 percent protective for men although male circumcision alone doesn't prevent HIV transmission; possibly some direct protection for women; many other health benefits for males (e.g. for penile cancer; some STIs, phimosis) and for females (esp. reduced risk of cervical cancer).	Prepare for potential roll out of MC as further data become available: acceptability, feasibility, costing, etc., required; some countries ready for national consultations to consider regarding roll out, others less so.	Countries vary in their readiness to consider male circumcision where it is not traditionally practised. UNAIDS and WHO are developing tools, guides and manuals for safe MC practice and programming. Major challenges include preventing unsafe practice and avoiding behavioural disinhibition (reduced partnerships and consistent condom use are still needed).
Counseling & testing	Little population-level impact shown, although essential as an entry point to care and treatment, and for PMTCT.	Some behaviour change shown in discordant couples and in HIV-positive clients.	Expand to national "know your status" campaigns in conjunction with post-test services; also part of effort to reduce stigma and increase openness.	Concern that "know your status" campaigns must link with effective and available post-test services for HIV-positive and HIV-negative clients, or they may not be effective.
Behaviour change interventions for young people	Talioires consultation in 2004: strongest evidence for behavioural impacts of: Radio with other media and TV/radio with other media; Certain designs of curriculum-based sex and HIV education shown to be effective for young people in school when adult led, no evidence of increased sexual activity.	Increased individual access to youth- (and gender-) friendly health services also shown to be important for general SRH in various studies. Young men and women recognized as essential to reach with effective multi-pronged strategies.	Proven strategies should be scaled up with strong quality control measures in place and improved M&E where possible, likewise for promising but as yet unproven strategies to strengthen the evidence base.	Data indicate behaviour changes through different strategies that are likely to have an impact on HIV incidence in young people. Community interventions with young people: weak evaluation designs and incomplete information, so not possible yet to assess impact clearly of different approaches. Look out for Talioires final report.

Focus	Impact at population level	Impact at individual level	Recommendations or comments from the meeting	Comments
Preventing Intergenerational sex	Rates of HIV in young women correlate with wider age disparity in relationships although population level modeling suggests a limited impact on overall HIV incidence through reduced age mixing.	Young women more susceptible to infection if immature vagina, as virgins, unempowered to insist on condom use or to protect self from sexual abuse. Young women can individually reduce some risk by avoiding older partners.	Focus needs to be predominantly on changing adult male behaviours and attitudes, while also empowering young women.	More research and action is needed regarding adult men involved in intergenerational and age-disparate sex as a major route for HIV infection in young women.
Preventing sexual violence	Likely contribution of sexual violence to HIV transmission, though population level impact not known.	Forced sex likely to confer higher HIV risk due to tearing, abrasion; also leads to impaired decision-making capacity, self-efficacy and increased likelihood of perpetuating abusive relationships; current prevention interventions target only "decision-enabled" individuals.	Growing recognition that reducing sexual violence will reduce HIV infection risk; human rights issue to prevent sexual violence against females and males. Efforts against sexual violence must be strengthened within communities, by leadership and through legislation.	Sexual violence is high, estimate given of 10 percent of all children per year in this sub-region.
ARV chemo-prophylaxis	No RCT undertaken of impact of ART on HIV transmission, but viral load is very low, which correlates with low infectivity; One observational study found 50 percent reduction of HIV transmission in discordant couples with AZT alone (Musicco et al., 1994); Pre-exposure prophylaxis (PREP) — premature halt to Tenofovir trials; Post-exposure prophylaxis (EP) —evidence from needlestick injuries and reducing mother-to-child transmission of HIV; Gel formulations being tested for microbical use.	Risk if individuals stop ART or engage in HIV risk behaviours that increase viral shedding as this could increase infectivity.	Need "proof of concept" and Post EP—feasibility of intervention study—currently underway (Cohen et al., HPTN 052); Microbicides—phase I completed of Tenofovir gel—safety profile good; PREP—challenges in undertaking trials.	Several challenges to address in using ART for HIV prevention: cost, and need for VCT and strong health infrastructure; may increase behavioural risks; and, if adherence is suboptimal, could increase drug resistance as well as reduce impact on prevention as viral load rises.
Vaginal interventions washing/dry sex	Wide population data not available.	One study showed increased individual risk with vaginal washing; Dry sex appears to increase transmission risk.	More research is needed on vaginal washing/douching, and also on dry sex and other intra-vaginal practices.	Dry sex is fairly common in the region and should be discouraged as it increases abrasions; gender issues are centrally involved.
Female diaphragm	RCT underway in Zimbabwe and South Africa, results in 2007.	By covering the cervix, likely to confer a degree of protection, but extent not known.	Research findings needed.	Diaphragm is potentially protective to some degree and is entirely female controlled. Could be used with microbicide when available.
Microbicides	None yet available, many candidate microbicides in Phase I-III trials in Malawi, Zimbabwe, South Africa, Zambia, Uganda and outside the region.	Not clear what level of protection, hoped at least 50%.	Countries should begin to prepare for microbicide trials and, over time, availability.	Microbicides will not be available till 2010 or later; but have great potential as female-controlled method.



Annex 2: Participant List

EXPERT THINK TANK MEETING ON HIV PREVENTION IN HIGH- PREVALENCE COUNTRIES IN SOUTHERN AFRICA 10 - 12 MAY 2006 MASERU, LESOTHO

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Annex 3: Meeting Agenda

EXPERT THINK TANK MEETING ON HIV PREVENTION IN HIGH- PREVALENCE COUNTRIES IN SOUTHERN AFRICA

Date/Time	Presentation Topic/Discussion	Presenter(s)
Wednesday, 10 May		
Rapporteurs	Mark Stirling, Daniel Halperin, NACs: Botswana, Malawi	
Session One - Introduction		
9:00-9:10	Welcome Remarks	Antonica Hembe, SADC
9:10-9:40	Meeting Participant Introductions	
9:40-10:45	Brainstorming Exercise	Alex Coutinho, Facilitator
10:45-11:00	Coffee/Tea Break	
11:00-11:30	HIV Prevention Focus/Meeting Objectives Introduction of Draft Propositions	Helen Jackson, UNFPA
Session Two – Setting the Stage		
11:30-12:30	Epidemiological and Behavioural Surveillance Evidence Southern Africa Review Panel	Innocent Ntaganira, WHO Daniel Halperin, USAID
12:30-13:30	Lunch Break	
13:30-14:30	Plenary Discussion of Epidemiological & Behavioural Surveillance Evidence	Alex Coutinho, Facilitator
14:30-15:00	Official Opening	Antonica Hembe, SADC Keketso Sefeane, NAC Lesotho, Agathe Lawson, UNFPA
Session Three – Key Factors in Incidence Decline		
15:00-16:00	Evidence of Country-Level Change and Lessons Learned from Uganda, Zimbabwe and Kenya Panel (Revisiting the ABC Strategy - Is it working now in Uganda?)	Sam Okware, MOH, Uganda Clemens Benedikt, UNFPA David Alnwick, UNICEF
16:00-16:15	Coffee/Tea Break	
16:15-17:30	Plenary Discussion of Country-Level Change and Incidence Decline	Alex Coutinho, Facilitator
17:30	Closure Day One	
Thursday, 11 May		
Rapporteurs	Agathe Lawson, Louise Thomas-Mapleh, NACs: Swaziland, Zambia	
8:30-8:45	Summary Review of Day One	Mark Stirling, UNAIDS
Session One: Behaviour Change and Social Norms		
8:45-10:45	Panel Presentations - Behaviour Change Strategies – What can we say about ABC? And Concurrency, Sexual Networking, Acute Infection and Highly Vulnerable Groups - Condom Impact on HIV Transmission - Intergenerational Sex - Gender-Based Violence	Innocent Modisaotsile, SADC Daniel Halperin, USAID Helen Jackson, UNFPA Suzanne Leclerc-Madlala, UKZN Neil Andersson, CIET

10:45-11:00	Coffee/Tea Break	
11:00-12:30	Plenary Discussion of Behaviour Change and Social Norms	Innocent Modisaotsile, Facilitator
12:30-13:30	Lunch Break	
Session Two Services for HIV Prevention		
13:30-15:15	Panel Presentations on: - Male Circumcision - Counseling and Testing, Discordancy - STI Treatment Impact on HIV Transmission - Microbicides Update - Positive Prevention	Alex Coutinho, Facilitator Bertran Auvert, INSERM Kevin O'Reilly, WHO Francis Ndowa, WHO Quarraisha Abdool-Karim, UKZN Alex Coutinho
[Working]	Coffee/Tea Break	
15:15-16:30	Plenary Discussion of Prevention Services	Alex Coutinho, Facilitator
16:30-18:30	Break-away Group Discussions on Exceptional Priority Actions to Recommend	

Friday, 12 May		
Rapporteurs	Alex Coutinho, Antonica Hembe, NAC: Zimbabwe	
Session One		
8:30-9:15	Rapporteur Presentations on Exceptional Priority Actions	Alex Coutinho, Facilitator
9:15-10:30	Group Discussion of Recommended Priority Actions	Alex Coutinho, Facilitator
[Working]	Coffee/Tea Break	
10:30-12:30	Break-away Group Discussions on: - Priority Recommendations for Action to SADC by NACs - Priority Recommendations for Action by International Cooperating Partners - Priority Recommendations for Research	NACs, ICPs, Researchers
12:30-13:00	Rapporteur Presentations of Priority Recommendations by NACs, ICPs and On Research	
13:00-14:00	Lunch Break	
14:15-14:30	The Way Forward	Antonica Hembe, SADC
14:30-15:15	Closing Addresses and Meeting Closure	Keketso Sefeane, NAC, Lesotho Mark Stirling, UNAIDS



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Low-Beer D, Stoneburner RL. Behaviour and communication change in reducing HIV: is Uganda unique? *African Journal of AIDS Research* 2003;2(1):9-21.

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Annex 5: CD Contents

EXPERT THINK TANK MEETING ON HIV PREVENTION IN HIGH- PREVALENCE COUNTRIES IN SOUTHERN AFRICA

Presentations

Propositions for HIV Prevention: Helen Jackson
An Epidemiological Overview of the HIV/AIDS Epidemic in Southern Africa, Including the Latest Trends: Dr Emil Asamoah-Odei
Why is HIV Prevalence so Severe in (Southern) Africa?: Daniel Halperin, PhD
Revisiting the ABC Strategy: Is it Working in Uganda? Dr Sam Okware
Declining HIV Prevalence in Kenya, Dr Isaiah K Tanui
HIV Decline and Behavioural Change in Zimbabwe – A Short Summary of 2005 Review Findings and Discussions: Clemens Benedikt, PhD
What Can We Say about “ABC” (Will People in Generalized HIV Epidemics—Actually do A, B or C?): Daniel Halperin, PhD
Condoms and HIV Prevention in High Prevalence Countries: Helen Jackson
Intergenerational Sex in Sub-Saharan Africa: Suzanne Leclerc-Madlala, PhD
Forced Sex and AIDS Prevention: Dr Neil Andersson
HIV and Male Circumcision: Dr Bertran Auvert
Systematic Review of VCT in Developing Countries: Dr Kevin O’Reilly
Impact of Treatment of Sexually Transmitted Infections on HIV Transmission: Dr Francis Ndowa
Microbicides: Quarraisha Abdool-Karim, PhD
Positive Prevention: Dr Alex Coutinho

Evidence documents

ARV chemoprophylaxis
Condoms
Counseling and testing
HSV-2
Intergenerational sex
Male circumcision
Microbicides
STIs
Talloires main findings for young people
Vaginal washing and female diaphragm
Zimbabwe prevalence decline

Selected documents

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