

OUT OF FOCUS



HOW MILLIONS
OF PEOPLE
IN WEST AND
CENTRAL AFRICA
ARE BEING LEFT OUT
OF THE GLOBAL
HIV RESPONSE



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ACRONYMS USED IN TEXT

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
CAR	Central African Republic
CSS	Community Systems Strengthening
DBS	Dried Blood Spots
DRC	Democratic Republic of Congo
ESA	East and Southern Africa
FDC	Fixed-Dose Combination
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
HTS	HIV Testing Services
IASC	Inter-Agency Standing Committee
MSM	Men who have Sex with Men
NGO	Non-Governmental Organisation
OECD	Organisation for Economic Cooperation and Development
OI	Opportunistic Infection
PCR	Polymerase Chain Reaction
PEPFAR	US President's Emergency Plan for AIDS Relief
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-to-Child Transmission
SMS	Short Message Service (text messaging)
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
USD	United States Dollar
WCA	West and Central Africa
WHO	World Health Organization



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Globally, the years 2000 to 2015 saw the scaling-up of access to antiretroviral therapy (ART), with a 35% decrease in AIDS-related deaths since 2005.¹ A record number of almost 16 million people living with HIV (PLHIV) have been initiated on ART as of mid-2015², three in four of whom live in sub-Saharan Africa, where the needs are most acute. Civil society and public health services alike have rallied to bring new evidence-based treatments and best practices to PLHIV.

Building on this success, in 2015 the Joint United Nations Programme on HIV/AIDS (UNAIDS) set ambitious global targets to be achieved by 2020.³ Referred to as '90-90-90', their aim is that 90% of all PLHIV will know their HIV status; 90 % of all people with diagnosed HIV infection will receive sustained ART; and 90% of all people on ART will achieve viral suppression.

While this fast-tracking of the HIV response is expected to prevent 75% of new infections by 2020, UNAIDS warns of the negative consequences of failing to reach these targets by the deadline: *"The epidemic will have rebounded by 2030, representing an even more serious threat to the world's future health and well-being and requiring substantial resources for what would then be an uncontrolled epidemic."*⁴

While the trend in international health funding for HIV/AIDS and ART, and the policies that drive the funding, has been to focus on high-burden countries and HIV 'hotspots' in Sub-Saharan Africa, most countries in the region classified by the UN as the West and Central Africa (WCA) region have been neglected. The WCA region is made up of 25 countries, most of them with relatively small populations. Their

1 UNAIDS, The Gap Report, 2014, available from: http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf

2 UNAIDS, Fact Sheet 2015, Global Statistics, World Aids Day 2015. Available from: <http://www.unaids.org/en/resources/campaigns/HowAIDSchangedeverything/factsheet>

3 This UNAIDS initiative aims to end the AIDS epidemic by 2030 by focusing within the key 2015-2020 time window on 30 countries that account for more than 80% of the world's new HIV infections – including several countries in West and Central Africa. For more, see: UNAIDS, *Fast-track: Ending the AIDS epidemic by 2030*, UNAIDS, 2014, available from: http://www.unaids.org/en/resources/documents/2014/fast_track as well as: UNAIDS, 2016-2021 Strategy. On the Fast-Track to End AIDS, October 2015, available from: http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

4 UNAIDS, *Fast-Track: Ending the AIDS epidemic by 2030*, 2014. Available from: http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf

1. INTRODUCTION

average prevalence rates are relatively low compared to Southern Africa. However, most of these countries struggle to offer ART to those who need it, their failures leading to excess mortality and morbidity, as well as limiting their ability to curb the spread of disease. In the WCA region, 76% of those who need antiretroviral therapy – a total of five million people – are still awaiting treatment.⁵ The unmet needs in most of these countries are slipping further out of focus.

In WCA, ART coverage rates lag behind those of Southern Africa. While countries faced with an overwhelming HIV burden have risen to the challenge by making major changes to their health services, countries in WCA have had less incentive to adapt their service delivery models, and less support to do so. Many also struggle with weak health systems and competing health priorities, problems which are exacerbated in places which are prone to recurrent crises. Many countries in WCA failed to implement some of the innovative methods used elsewhere for rolling out ART, due to resistance or a lack of awareness, instead resorting to ill-adapted approaches. Alternative solutions to meet the needs in these specific contexts are urgently required.

Over one in four AIDS-related deaths worldwide occur in WCA and four in ten children dying from AIDS succumb in WCA.⁶ Over one in four AIDS-related deaths worldwide occurs in WCA, while four in every ten children who die from AIDS succumb in the region. Unless the current failures of policy and international health financing to tackle the growing epidemic within this region are addressed, the chances of reaching the new and ambitious goals of 90-90-90 are very slim indeed.

With the world focusing on changing the course of the HIV pandemic within the next five years, this may represent the only chance for people in WCA to access lifesaving treatment. The *Fast-Track* initiative to reach the 90-90-90 goals should also benefit the people of WCA.

Médecins Sans Frontières (MSF) works across the globe providing HIV services to PLHIV, including projects in the WCA region. In 2014, MSF teams provided care for 229,900 PLHIV, and supported ART for 226,500 people in 19 countries worldwide.⁷ MSF teams have first-hand experience of the grave consequences for people unlucky enough to live in countries that have not benefited from the global antiretroviral (ARV) revolution.

This report aims to highlight the shortfalls in policy and practices for PLHIV in WCA countries that face significant treatment gaps. It points to key obstacles to boosting ART coverage in WCA, focusing on contexts where MSF is involved in the HIV response. It brings together the experience of MSF teams, including data from local pilot projects, small-scale patient data collection, patient surveys and other programmatic information.

Lessons learnt on HIV treatment scale-up in Southern African countries and elsewhere could be game changers for PLHIV in WCA. However, certain policies and approaches currently being applied will need modification, due to the scope and spread of the epidemic due to stigma against PLHIV and due to specific weaknesses in the existing health systems which hinder the quality of and access to ART. The report describes pilot projects with alternative approaches, both in WCA and elsewhere, and their potential to break through the current status quo. Three case studies from countries in the region – Democratic Republic of Congo (DRC), Central African Republic (CAR) and Guinea – demonstrate the main obstacles to and opportunities for expanded and accelerated ART initiation and retention in care.

Our observations highlight the urgent need to overcome the current status quo and develop an adapted fast-track action framework for the countries in WCA. Concrete proposals for a catch-up plan to close the treatment gap in WCA are included in this report, including the call to triple ART initiations by 2020 in countries with less than 50% HIV treatment coverage, and to transfer knowledge and experience from places that have effectively rolled-out ART provision.

⁵ ONUSIDA, TDR Consultation régionale sur 90-90-90 avec les implémentateurs en Afrique de l'Ouest et du Centre, Dakar, novembre 2015.

⁶ *Ibid.*

⁷ For more information on MSF activities in 2014, see the international activity report, available on: http://www.msf.org/sites/msf.org/files/msf_international_activity_report_2014_en.pdf

2. THE SCALE OF THE PROBLEM IN WEST AND CENTRAL AFRICA

3 OUT OF 4 DON'T HAVE ACCESS TO ARV
(ANTIRETROVIRAL DRUGS)



9 OUT OF 10 CHILDREN DON'T HAVE ACCESS TO ARV TREATMENT



Source UNAIDS 2014

A lack of public visibility and low political priority given to HIV/AIDS have resulted in poor knowledge of the disease among the general population, political leaders and health workers. This has led to, among other things, low availability of testing services, treatment and care, with health services poorly adapted to specific needs, and with barriers to accessing care for PLHIV. Demand for HIV services is hindered by stigma, misinformation and discrimination.

Note:

While robust data collection at country-level is a challenge anywhere, caution is needed in terms of the validity, accuracy and completeness of data available for HIV epidemiology and programmes in the WCA region. Data and information collection methods vary widely according to the source; patient files and health facility reporting are not systematic; reporting is often incomplete. This imposes significant limitations to countrywide extrapolation and interpretation of available data.

2.1 LOWER HIV PREVALENCE BUT LARGE NUMBERS OF PEOPLE LIVING WITH HIV

The WCA region as a whole is significant in terms of population size, geographic spread and the scope of needs in terms of HIV. Lying as it does outside the high-prevalence HIV belt in Southern Africa, the region is struggling to strengthen and expand its HIV treatment services, as is often the case for countries with lower HIV prevalence (i.e. below 5%). A recent analysis showed ART coverage in adults, pregnant women and children is significantly lower in countries with lower prevalence, as can be seen in table 01, based on 52 countries.⁸ Yet, half of all PLHIV live in countries with lower HIV prevalence, and all countries of the WCA region have an estimated prevalence below the 5% threshold.

⁸ Andrew Hill et al., Countries with lower HIV prevalence have lower ARV coverage: UNAIDS 2014 database. Poster presented at the CROI conference, Boston, USA, February 2016.

WEST AND CENTRAL AFRICA



21%
OF NEW **HIV**
INFECTIONS



27%
OF DEATHS
BY **HIV/AIDS**



45%
OF CHILDREN
BORN WITH **HIV**

Source UNAIDS 2014

Table1:
ART coverage rates in countries with lower and higher prevalence.

Treatment coverage in lower versus higher prevalence countries		
	Lower prevalence (<5% HIV+ in adults)	Higher prevalence (≥5% HIV+ in adults)
Countries	40	12
Total HIV Epidemic size	16.0 million	16.1 million
Adult HIV prevalence	1.6%	14.6%
% Adults on ART	31.7%	48.3%
% Children on ART	22.4%	42.6%
% Pregnant women on ART	46.7%	89.1%
% Pregnant women with ≥4 ANC	55.3%	68.1%
% Infants given EID test	20.1%	72.3%
Annual Death rate, HIV	4.5%	2.5%
Annual HIV transmission rate	6.2%	5.4%

Source: Andrew Hill *et al.*, *Op.Cit.*

SNAPSHOT OF HIV IN WCA

- WCA consists of 25 countries with some 425 million inhabitants, with a high proportion of young people (some 25% of the population is between 10 to 19 years of age).⁹
- The relatively low average HIV prevalence – 2.3% in 2014¹⁰ – represents around 6.6 million PLHIV, which was 17.9% of the global HIV burden that year. The region accounts for 21% of new HIV infections worldwide and 45% of new infections in children^{11, 12}
- While AIDS-related deaths are in decline globally, the contribution by WCA countries to annual AIDS mortality in Sub-Saharan Africa rose to 36% in 2013.¹³
- Overall national low-prevalence figures conceal a high burden and a high incidence of HIV within specific groups or geographic areas. Especially vulnerable groups include sex workers, men who have sex with men (MSM), people who inject drugs, migrants and displaced populations.
- At the end of 2014, 76% of people of the region who should be on ARVs were not receiving treatment, including nine out of 10 children with HIV.¹⁴
- WCA includes three of the six countries worldwide that face the triple threat of a high HIV burden, low treatment coverage and little or no decrease in HIV infections. These are the Central African Republic, the Democratic Republic of Congo and Nigeria.¹⁵
- Six out of 25 countries in the WCA region account for 83% of PLHIV in the region, with Nigeria accounting for 52%, Cameroon for 10%, Ivory Coast for 7%, DRC for 7%, Ghana for 4% and Chad for 3%.¹⁶

⁹ UNICEF, Young people in West and Central Africa: Trends, Priorities, Investments and Partners, July 2009. Available from: http://www.unicef.org/wcaro/english/YoungPeopleinWestandCentralAfrica-finaldraft_20-7-09.pdf.pdf

¹⁰ ONUSIDA, *Op.Cit.*

¹¹ This is fourfold the worldwide prevalence (0.8%). Source: UNAIDS, How AIDS changed everything, 2015

¹² UNAIDS 2014 data, available from <http://aidsinfo.unaids.org/#>

¹³ Regional Discussion paper for consultations on UNAIDS Strategy 2016-2021 Development in West and Central Africa, February 2015, Dakar.

¹⁴ Concept note of UNAIDS' Regional Consultation on Paediatric Care in West and Central Africa: Active Search for Children Living with HIV, November 2015, Dakar.

¹⁵ UNAIDS, Regional consultation on care and treatment for people living with HIV in West and Central Africa, December 2012, Dakar.

¹⁶ Analysis based on UNAIDS data received upon request by MSF, October 2015.

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2.2 LACK OF HIV TESTING SERVICES

MSF's experience in WCA supports evidence that while HIV testing services (HTS)¹⁷ in the region have increased, they remain largely inadequate. Even in population groups which are usually prioritised – such as pregnant women, children exposed to HIV, and tuberculosis (TB) patients – HIV testing services remain dramatically low.¹⁸

Additionally, the Ebola epidemic in Western Africa resulted in HIV testing services being suspended or heavily reduced in Liberia, Sierra Leone and Guinea for much of 2014-15.

Provider-initiated testing is often preferred over community-based voluntary testing and counselling, because of concerns with efficiency in low-prevalence settings. However, our experience shows that HIV testing services are rarely offered systematically and that various barriers to accessing public services also hinder their uptake. With stockouts of tests, patient fees, a lack of knowledge or reluctance on the part of clinical staff to propose testing as well as a lack of counselling, HIV testing services are not receiving the priority they deserve. Additionally, clinicians tend to reserve HIV tests for diagnosing patients who are already ill, thus reducing the proportion of testing available to the general population and delaying the start of ART for those who are HIV-positive but not yet ill. MSF's experience in WCA shows that many patients with a

¹⁷ As per WHO, HTS include the full range of services that should be provided together with HIV testing. These include pre-test information, post-test counselling, linkage to appropriate HIV prevention, care and treatment services, etc. For more, see: <http://www.who.int/hiv/topics/vct/about/en/>

¹⁸ WHO, Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. WHO; Geneva, July 2014. Available from: <http://www.who.int/hiv/pub/guidelines/keypopulations/en/>



long medical history and obvious clinical signs have never been tested for HIV, despite previous contacts with health services. In DRC for example, a study carried out by MSF in 2012 showed that, even in hospitals, HIV testing is far from systematic; when MSF teams offered HIV tests and counselling to inpatients in the internal medicine wards of three Kinshasa hospitals, 90% said they had never been offered an HIV test before.¹⁹

Community-based HIV testing is recommended by the World Health Organization (WHO) as a very effective approach, but it is neither well developed nor funded in WCA. In CAR, for example, voluntary and community testing activities were reduced after the Global Fund²⁰ suspended its funding in 2009, and were further affected by the 2013 civil unrest. In DRC, a policy decision in 2008-09 prioritised health facility HIV testing services sites over community-based HIV testing. (See CAR and DRC case studies.)

Because the priority today is to identify HIV-positive people as early as possible, the need for HIV testing services is even more pressing. However, a lack of systematised provider-initiated testing, and a lack of proactive testing campaigns, including in communities, make it likely that PLHIV will not be diagnosed until they are at an advanced stage of the disease. This, in turn, increases the health and social costs of morbidity and mortality associated with secondary infections, complications and hospitalisation.

¹⁹ Médecins Sans Frontières, Dépistage et Conseil initiés par le prestataire dans les services de médecine Interne et de pédiatrie dans 3 structures de santé à Kinshasa. JMS, 2012.

²⁰ The Global Fund to Fight AIDS, Tuberculosis and Malaria (often called the Global Fund or GFATM) is an international financing mechanism that aims to attract and disburse additional resources to prevent and treat HIV and AIDS, tuberculosis and malaria. For more, see: www.theglobalfund.org

"In 2003 I saw a poster urging people to get tested for HIV, so I went to Ignace Deen hospital to do a test as part of a general health check. The staff tried to dissuade me, saying that I looked healthy, but after some time they did take my blood. When the staff gave me the results they said that everything was good. I asked if they also tested for HIV but they hadn't. So they took my blood again and told me to wait. I didn't receive any pre-test counselling

I waited from 9am to 1pm and the results still weren't there so I had to leave. After a few days of waiting I came back. My blood was taken again and then the result came. The nurse said she couldn't give me the result because there was no doctor, I had to go find a doctor myself. As I didn't know who to ask I insisted to be given my result. When I opened the file I saw that the result was positive but I didn't understand what it meant.

I was told to go to the blood bank where people explained that in order to be tested I had to agree to give blood if the result was negative, and I would be let go if it was positive. They took my blood, and after waiting for the whole afternoon I finally forced myself into a room marked "counsellor" to demand my result. I was then told that there was an "anomaly" in my blood and that I had to come back the day after. This night I was quaking with fear, I didn't sleep at all.

I came back the day after and I waited from 7am to 11am, until someone told me to come back in a week. I did so, my blood was taken again and I waited for three weeks, going there every day without ever getting my result. One day, I said "this has to stop, I need to know". A doctor threw at me a piece of paper with the results on it, saying "Madame, you've got AIDS, you have seven years to live. Go to Donka, there's a doctor who take care of this there".

I took the paper, I was shaking, so desperate that when I came home I undressed, took a knife and pressed it against my belly. I wanted to kill myself.

Thankfully I was taken care of in Donka hospital and today I live positively and I have a 3.5 years old little boy who is HIV negative".

Female Patient, 32 years old, Conakry

2.3 LOW ANTIRETROVIRAL TREATMENT COVERAGE

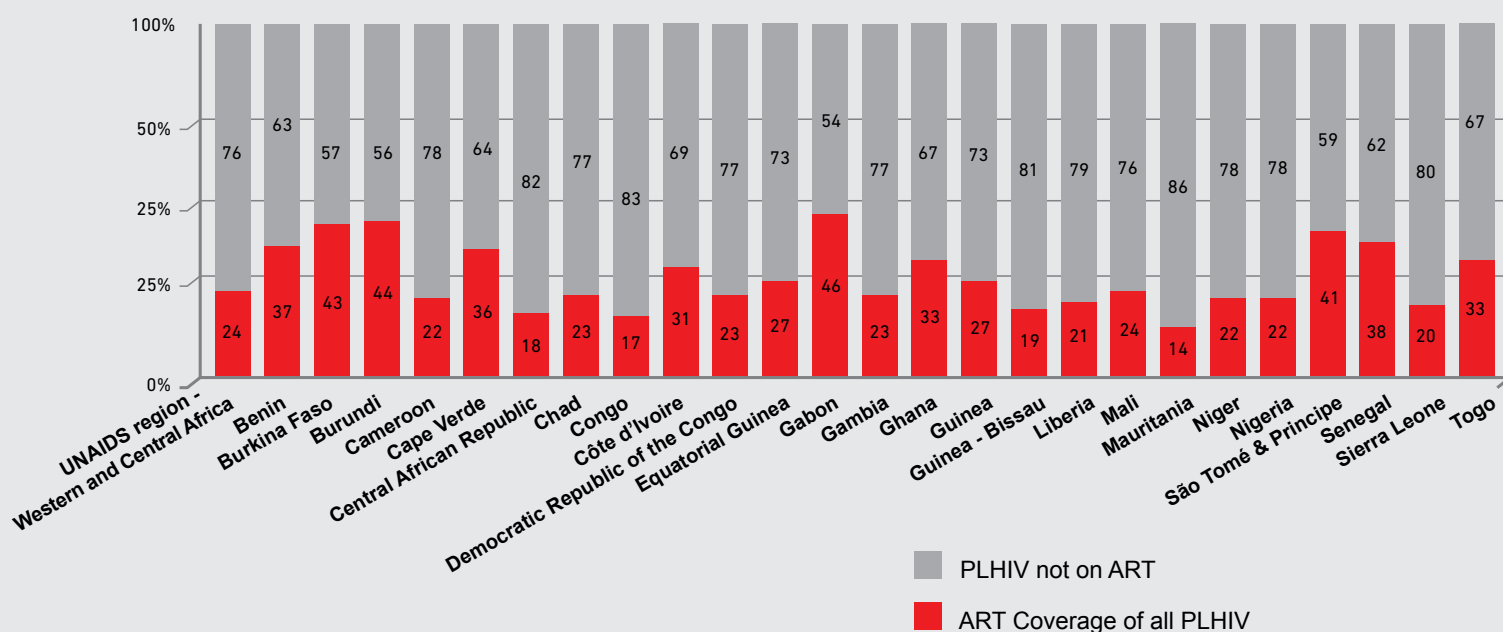
ART coverage in WCA was 24% in 2015.²¹ This means that an estimated five million PLHIV in WCA needing treatment are not receiving it. Of these, 2.5 million are in Nigeria and 0.5 million are in Cameroon.²²

While the percentage of ART coverage has increased over the past year, the regional coverage is far from homogenous, and the latest figures hide a wide variation between countries. Some countries, such as Gabon and Burkina Faso, report that as much as 40% of the ART needs are covered, while other countries remain below the 25% threshold, including CAR, Republic of Congo, Guinea-Bissau and Mauritania (see figure 1). ARV coverage in WCA remains well below the average for Sub-Saharan Africa (42%) and for the East and Southern Africa (ESA) regions (47%). While 10 out of the 19 million people living with HIV in ESA are still awaiting treatment, 5 of the 6.6 million PLHIV in the WCA region currently don't have access to ART. PMTCT coverage differs widely too: 88% in ESA versus 42% in the WCA region.

Although with higher numbers of PLHIV and HIV prevalence, the ESA region lost around 460,000 people to HIV in 2014, while 330,000 people died of the HIV related causes in WCA. Figure 2 allows a comparison of adult ART coverage between countries from these two different regions.

The number of people starting treatment in WCA is still outstripped by the number of new infections, indicating that the region is far from reaching the 'tipping point'. In 2014, close to 300,000 people started ARV treatment in the region, while an estimated 420,000 new infections occurred.^{23, 24} Only four countries in WCA (Senegal, Benin, Burundi and Gabon) reported that the number of people initiating ART equalled or exceeded the number of estimated new HIV infections.²⁵

Figure 1:
ART coverage of PLHIV in the WCA region.



Source: West and Central Africa Region: Overview of the HIV epidemic and response, Presentation by UNAIDS RST-WCA Deputy Director at the Enda Santé/UNAIDS Regional Workshop on 3X90, 5-6 November 2015, Dakar.

²¹ UNAIDS 2014 data: available from <http://aidsinfo.unaids.org/#>

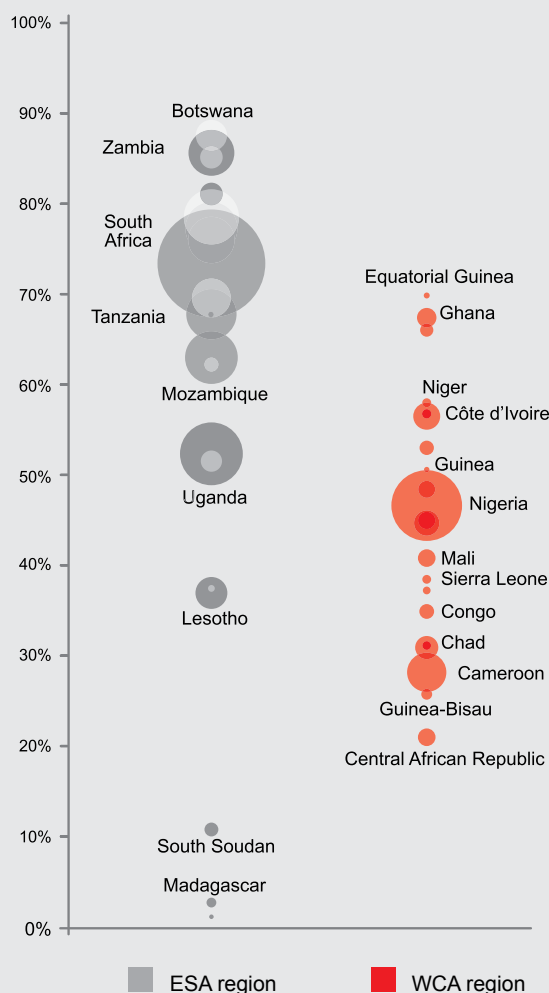
²² *Ibid.*

²³ UNAIDS data received upon request by MSF, October 2015

²⁴ UNAIDS 2014 data, *Op.Cit.*

²⁵ One, The AIDS report 2015, Unfinished business: Tracking Global Commitments on AIDS, Vol. 4, Available from: <http://www.one.org/us/aids-report>

Figure 2:
Comparing adult ART coverage between West & Central Africa Region and East & Southern Africa.



Source: Dutta A. et al. The HIV Treatment Gap: Estimates of the Financial Resources Needed versus Available for Scale-Up of Antiretroviral Therapy in 97 Countries from 2015 to 2020, PLOS Medicine | DOI:10.1371/journal.pmed.1001907, November 2015.

In WCA, figures for retention in care are scarce and cannot be extrapolated to country or regional estimates. In MSF-supported health facilities, retention varies widely according to the service delivery model. It ranges from 75% in Guinea (2013) to 78% in DRC (2014) and 63% in CAR (2014).²⁶ Experience has shown that patients who interrupt their ARV treatment do not necessarily disclose this when they re-enroll. A 2014 patient study in Kinshasa showed that 70% of patients presenting with severe illness had previously been on ART, of whom 52% had interrupted their treatment for periods of longer than three months.²⁷

Insufficient retention data, added to the often limited knowledge and experience of health staff managing treatment failure, means that the need to shift to second-line treatment is often underdiagnosed. This is further compounded by second or third-line ARVs being either scarce or unavailable.

"I used to have a small shop between Brazzaville and Kinshasa and at that time, I paid to get my ARVs. Unfortunately, when the Congolese were pushed out of Brazzaville I had to stop the treatment because I didn't have any money any more. So now, instead, I take other medicines that my friends sometimes give me, but they are not ARVs. Because I'm not getting treatment, I have become very sick. I have problems with my eyes, my skin, my head and my legs. My sadness is consuming me. When I look at my life, I feel depressed. There's heaviness in my heart. My heart aches.

I have seen a number of people die because they didn't have the money to buy their ARVs. It breaks my heart to see others suffer, getting sick and dying. I would like to have the government support us. I would like to have a place where we can get treatment".

Female patient, Kinshasa, DRC.

²⁶ These data cannot be extrapolated to the entire country, as they are based on a few HIV treatment sites. Moreover, in community-based and differentiated models of care, retention rates are far better.

²⁷ Mashako Maria, Forte mortalité intra-hospitalière de PVVIH à Kinshasa: Quelles stratégies pour y remédier?, Mémoire présenté en vue de l'obtention du diplôme de Master en Sciences de la Santé Publique Contrôle des Maladies, Anvers, IMT, Juin 2015.

2.4 HIGH HIV-RELATED MORTALITY AND SEVERELY ILL PATIENTS

As highlighted previously, WCA countries accounted for 36% of annual AIDS deaths in sub-Saharan Africa in 2013. Seven countries – Nigeria, Cameroon, DRC, Cote d'Ivoire, Chad, CAR and Ghana – accounted for 87% of AIDS deaths in the WCA region in the same year.²⁸

An observational mortality survey carried out in the city of Carnot, CAR, in 2012 found that one in three deaths among people aged 15 and above was reported as being attributed to HIV/AIDS.²⁹

A delayed start of ART, or a lack of retention to it, has been shown to considerably increase both morbidity and mortality.^{30, 31} Patients frequently arrive in an advanced state of the disease, severely immunosuppressed and with opportunistic infections (OIs). This contributes to preventable human suffering, overburdens health systems (particularly hospitals), and has a serious economic and social cost. In MSF-supported hospitals in CAR, our teams report that 25-29% of hospitalised patients suffer HIV-related illness, while an estimated 84% of all intra-hospital deaths are due to HIV. In the MSF-supported HIV ward in Kabinda hospital in Kinshasa, one in four HIV inpatients does not survive because they arrive very ill.

"What we see today in our projects in West and Central Africa sometimes reminds me of our early days in South Africa in 1999, setting up the first ART treatment programmes in the country. Too many of the patients we care for in our projects in the DRC, Guinea or CAR show advanced stages of Aids that have become relatively rare in South Africa since the mid-2000's. Incidence of advance stage IV presentation like crypto meningitis, disseminated TB and Kaposi sarcoma remains alarming".

Eric Goemaere, MSF HIV/TB referent.

²⁸ UNAIDS, Regional Discussion paper for consultations on UNAIDS Strategy 2016-2021 Development in West and Central Africa, February 2015, Dakar.

²⁹ Epicentre, Enquête de mortalité rétrospective dans la ville de Carnot, Préfecture de Mambéré-Kadéï, République Centrafricaine, Janvier - Juillet 2012.

³⁰ National Institutes of Health. Starting antiretroviral treatment early improves outcomes for HIV-infected individuals, May 2015. Available from: <http://www.nih.gov/news/health/may2015/niaid-27.htm>.

³¹ MSF (2010) The Ten Consequences of AIDS Treatment Delayed, Deferred, or Denied. July 2010. Available from: http://www.msf.or.jp/library/pressreport/pdf/Report_10consequences_highres.pdf





2.5 WOMEN AND CHILDREN FACE ART GAP

In WCA, nine out of ten children with HIV do not receive treatment. The region was home to 720,000 HIV-infected children under 15 years of age in 2014, but paediatric ARV coverage is just 11%.^{32, 33} Of all WCA countries, only Cape Verde has paediatric ART coverage above 20%, while in 12 out of 21 WCA countries, fewer than one in ten children have access to ART (see figure 3). Figure 4 illustrates the relative backlog in getting children onto ART in WCA countries compared to those in ESA.

While ART for adults increased by 4% in WCA from 2013 to 2014, it increased by just 1% for children.³⁴ Without a significant increase in the pace of initiations, the relative treatment gap for children will only grow further. Low numbers of children under ART are closely linked to insufficient detection in communities and health facilities. Health staff is poorly trained in paediatric HIV detection and care, while lab facilities for early infant diagnosis are scarce. Providing ART to HIV-positive children falters when paediatric ARVs are unavailable and when the necessary support for children and their families is lacking. Furthermore, stigma and legal concerns linked to parents' authorisation and disclosure to children contribute to low numbers of children being enrolled in ART.



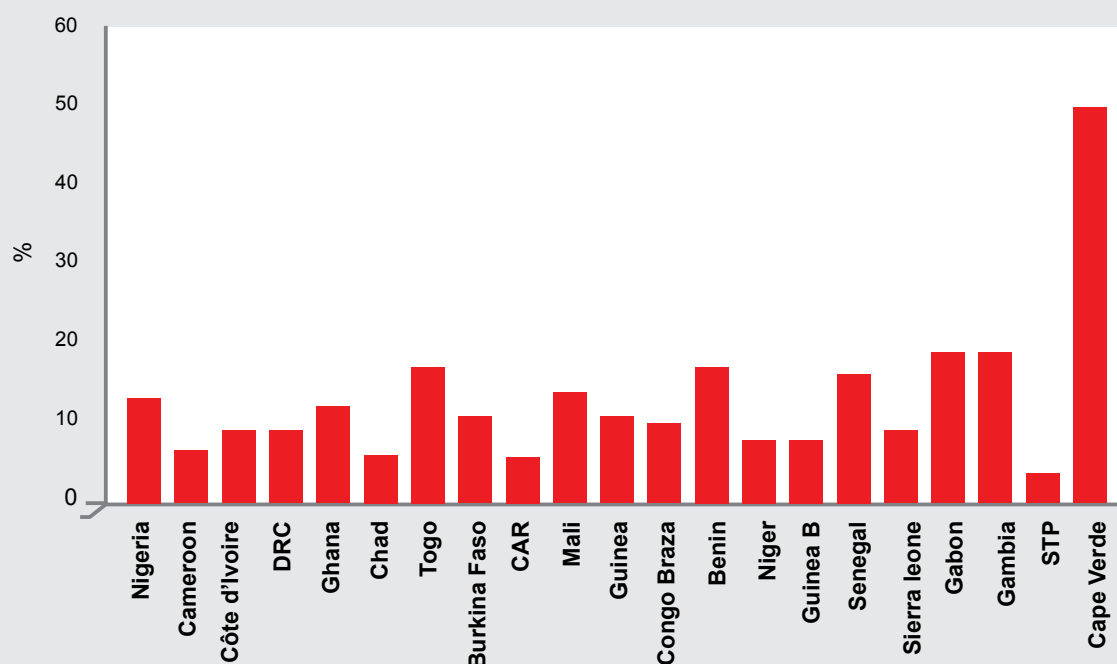
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³² UNAIDS, data received upon request by MSF, October 2015.

³³ UNAIDS, Concept Note for the Regional Consultation on Paediatric Care in West and Central Africa held in Dakar, November 2015.

³⁴ *Ibid.*

Figure 3:
Coverage of paediatric ART in West & Central Africa in 2013



Source: UNAIDS Concept Note for the Regional Consultation on Paediatric Care in West and Central Africa held in Dakar, November 2015. Note that data for four WCA countries are missing.

- Starting ART before the 12th week of life reduces HIV-related death by 75% among children living with HIV
- Without treatment, about one-third of children living with HIV will not survive their first birthday; half of them will not celebrate their second birthday and only one in five children will celebrate a fifth birthday.

Source: UNAIDS ³⁵

In addition, just 10% of infants of HIV-positive mothers in WCA are tested for HIV within two months of their birth, compared to 50% in Eastern and Southern Africa.³⁶ While important strides have been made in the prevention of mother-to-child transmission (PMTCT) through access to ARV drugs for pregnant women living with HIV, in WCA just 39% of the estimated 360,000 HIV-positive pregnant women received ARVs compared to 79% in the Eastern and Southern Africa regions in 2013.³⁷ Figure 5 illustrates the wide discrepancies between countries, with reported PMTCT coverage ranging from more than 81% in Ghana to just 47% in DRC.³⁸

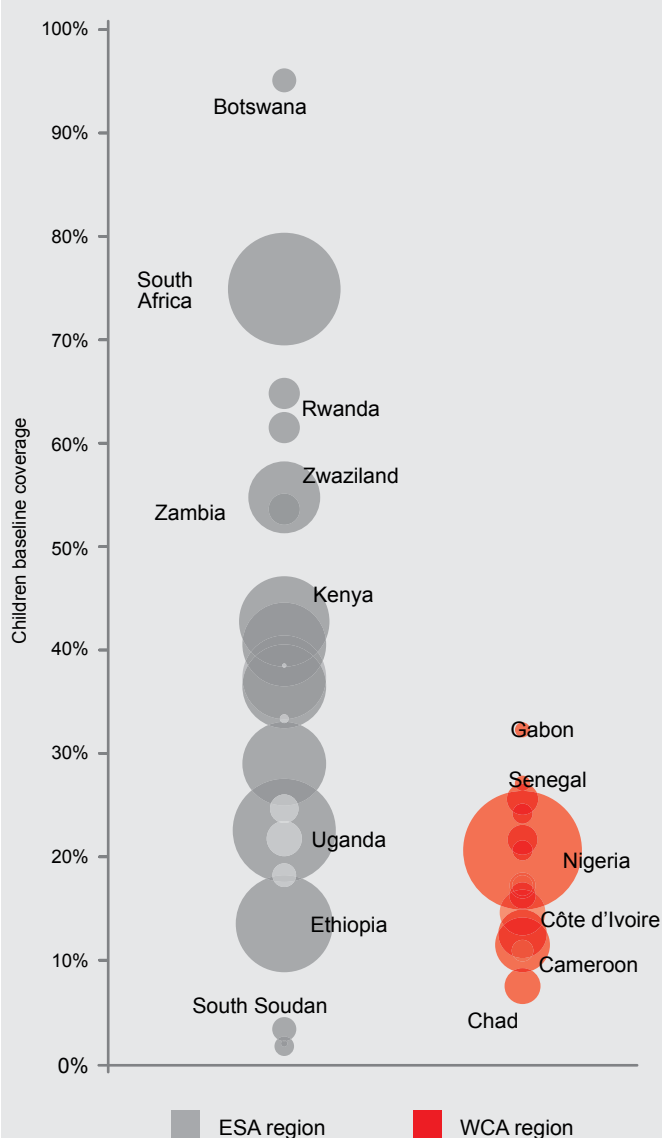
³⁵ UNAIDS, Global Aids Response Progress reporting, 2014.

³⁶ UNICEF, Progress for children: Beyond averages. Learning from the MDGs, New York, June 2015. Available from: [http://www.unicef.org/lac/Progress_for_Children_No_11_22June15\(2\).pdf](http://www.unicef.org/lac/Progress_for_Children_No_11_22June15(2).pdf)

³⁷ *Ibid.*

³⁸ UNAIDS, 2014 data, available from <http://aidsinfo.unaids.org/>

Figure 4:
Comparing paediatric ART coverage between West & Central Africa region and East & Southern Africa.



Source: Dutta A. et al. The HIV Treatment Gap: Estimates of the Financial Resources Needed versus Available for Scale-Up of Antiretroviral Therapy in 97 Countries from 2015 to 2020, PLOS Medicine | DOI:10.1371/journal.pmed.1001907, November 2015.

"When I came here four days ago to give birth a doctor offered to test me for HIV. I had never tested before, and the result was positive. For now I've been put on treatment and my baby too.

I had no idea I was at risk. Both my parents died of HIV/AIDS, but I didn't know they were infected; it's only after they passed away that I understood why. I lost a child some time ago, but I don't know why. I know that my seven year old daughter will need a test, but so far my husband has refused to be tested".

Patient at MSF Carnot clinic, Central African Republic.

While specific statistics for WCA are unavailable, globally it is estimated that 2.1 million adolescents were living with HIV in 2012.³⁹ Adolescents (aged 10-19 years) are the only age group in which AIDS deaths rose between 2001 and 2012. Globally, HIV is the main killer of this age group.⁴⁰ Additionally, among 15 to 19-year-olds, girls accounted for two-thirds of all new HIV infections in 2013.⁴¹ This fact demonstrates a major failure to prioritise adolescents in strategic planning, and a severe lack of access to adequate and adapted testing, counselling and ART.

"Both my parents passed away when I was a child, I don't know the reason for their death, I don't know if it's because of AIDS. Since primary school, I used to be sick all the time. It got so bad that when I was 15 I fell into a coma. During my hospitalisation I was diagnosed with HIV – what devastating news. My grandmother can't look at me without falling down crying... Thankfully when I was 16 I joined a support group for teenagers. There were 15 of us, and we could tell each other everything. What a change in my life".

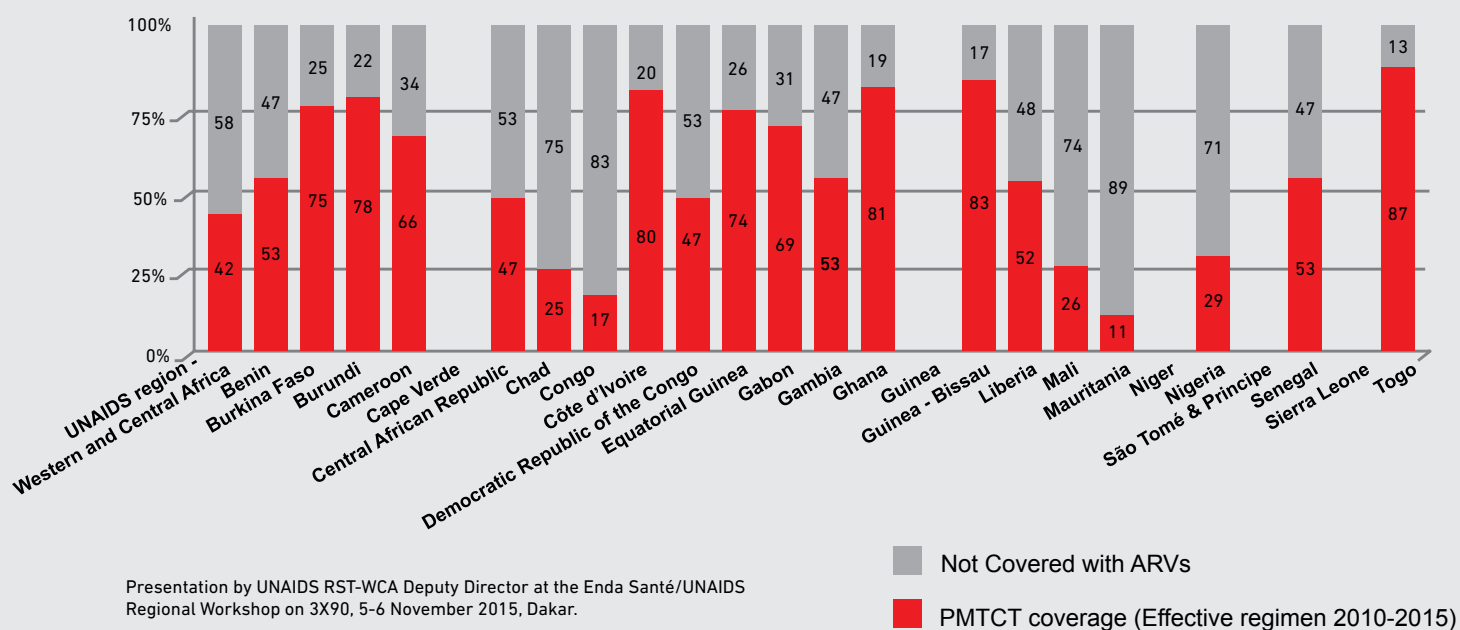
Teenage patient, Conakry, Guinea.

³⁹ Ibid.

⁴⁰ WHO. Health for the world's adolescents. A second chance in the second decade. Geneva, World Health Organization, 2014.

⁴¹ UNICEF, Progress for children: Beyond averages. Learning from the MDGs, New York, June 2015. Available from: [http://www.unicef.org/lac/Progress_for_Children_No_11_22June15\(2\).pdf](http://www.unicef.org/lac/Progress_for_Children_No_11_22June15(2).pdf)

Figure 5 :
West and Central Africa Region: Overview of PMTCT-coverage in 2014.



THE BENEFITS OF ANTIRETROVIRAL THERAPY (ART)

- **ART SAVES LIVES.** Today, the life expectancy of a person living with HIV on treatment is the same as that of an uninfected person.⁴² For every 1,000 people treated annually, 228 deaths are averted, 61 new HIV infections through sexual transmission are prevented and 26 infants are saved from infection.⁴³
- **STARTING ART EARLY HAS MULTIPLE BENEFITS.** A retrospective MSF study of 48 HIV programmes showed that early ARV initiation improves treatment outcomes and reduces HIV transmission. Notably, pre-treatment or pre-ARV deaths were higher among patients in an advanced stage of the disease, confirming the importance of early ARV initiation to reduce mortality.⁴⁴
- **ART REDUCES NEW INFECTIONS.** ART reduces the risk of HIV transmission by up to 96%, by reducing overall viral load within populations.⁴⁵ The causal link is most clear in children and young people, where HIV prevalence dropped from 11.2% in 2002 to 3% in 2008.⁴⁶
- **ART PREVENTS ILLNESS.** ART reduces the risk of TB infection among PLHIV by 65%.⁴⁷ In WCA, many people do not find out that they have the virus until they fall ill. By then, their immune system has been permanently damaged and they are vulnerable to life-threatening infections.⁴⁸

- **ART KEEPS PEOPLE PRODUCTIVE.** Investing in HIV treatment generates economic returns up to three times the investment, increasing productivity, preventing children from becoming orphaned and deferring the healthcare costs associated with advanced HIV-related illnesses.⁴⁹
- **ART REDUCES THE BURDEN ON HEALTH FACILITIES.** Widespread availability of ARV drugs has reduced the burden on health facilities, in particular the demand for inpatient and palliative care. In Busia, Kenya, the proportion of bedridden patients declined from 10% in 2004 to less than 2% in 2009 as a result of increased ARV coverage.⁵⁰
- **ART IMPROVES UPTAKE OF OTHER HEALTH SERVICES.** The offer of HIV care often leads to improved uptake of other services, such as antenatal care, hospital births, vaccinations, treatment of sexually transmitted infections and diagnosis of TB.^{51, 52} In MSF's project in Thyolo, Malawi, for instance, thanks to PMTCT initiatives as part of maternal health services the proportion of women (regardless of HIV status) delivering in health centres nearly doubled from 22% in 2006 to 41% in 2008.⁵³ Communities gained trust in health facilities and overall utilisation of care increased after the start of effective HIV care provision.
- **ART STRENGTHENS OVERALL HEALTH SERVICES.** ART programmes often result in broad improvements in health services, in terms of human resources, improved laboratory monitoring, pharmacy capacity and management, and more effective management of information and procurement systems.⁵⁴

42 UNAIDS, How AIDS changed everything. UNAIDS; Geneva 2015 (MDG6 report). Available from: http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf

43 Blandford J. Estimating health impact and costs of treatment in PEPFAR-supported programs. Washington, DC, PEPFAR Scientific Advisory Board, 2011.

44 Mathieu Bastard, Daniel P O'Brien *et al.*, Risk factors for mortality and loss to follow-up before antiretroviral therapy: a multi-centric, retrospective cohort study of 48 HIV programmes, 2014.

45 Cohen MS *et al.* Prevention of HIV-1 infection with Early Antiretroviral Therapy. NEMJ 365:493-505, 2011 Available from: <http://www.nejm.org/doi/full/10.1056/NEJMoa1105243>

46 Kavanagh M, Cohn J, Mabote L, *et al.* Evolving human rights and the science of antiretroviral medicine. Health and Human Rights Journal, 17/1, June 2015. Available from: <http://www.hhrjournal.org/2015/06/evolving-human-rights-and-the-science-of-antiretroviral-medicine/>.

47 Suthar AB *et al.* Antiretroviral Therapy for Prevention of Tuberculosis in adults with HIV: a systematic review and meta-analysis. PLoS Med, 2012, 9:e1001270. Available from: <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001270>

48 Shisana O, Rehle T, Simbayi LC, *et al.* South African national HIV prevalence, incidence, behavior and communication survey 2008: a turning tide among teenagers? June 2009. Available from: <http://www.health-e.org.za/wp-content/uploads/2013/05/2966e129fc39e07486250fd47fcc266e.pdf>

49 UNAIDS, Access to antiretroviral therapy in Africa. Status report on progress towards 2015 targets.

UNAIDS, Geneva 2013. Available from: http://www.unaids.org/sites/default/files/media_asset/20131219_AccessARTAfricaStatusReportProgressTowards2015Targets_en_0.pdf

50 MSF, A Model of HIV/AIDS Care and Treatment in a Rural Setting. The experiences of MSF in the Greater Busia District, Western Kenya (2000 – 2010). April 2010. Available from: https://www.msf.es/sites/default/files/publicacion/KE_Busia%20Report_04%202010_25-05-2010.pdf

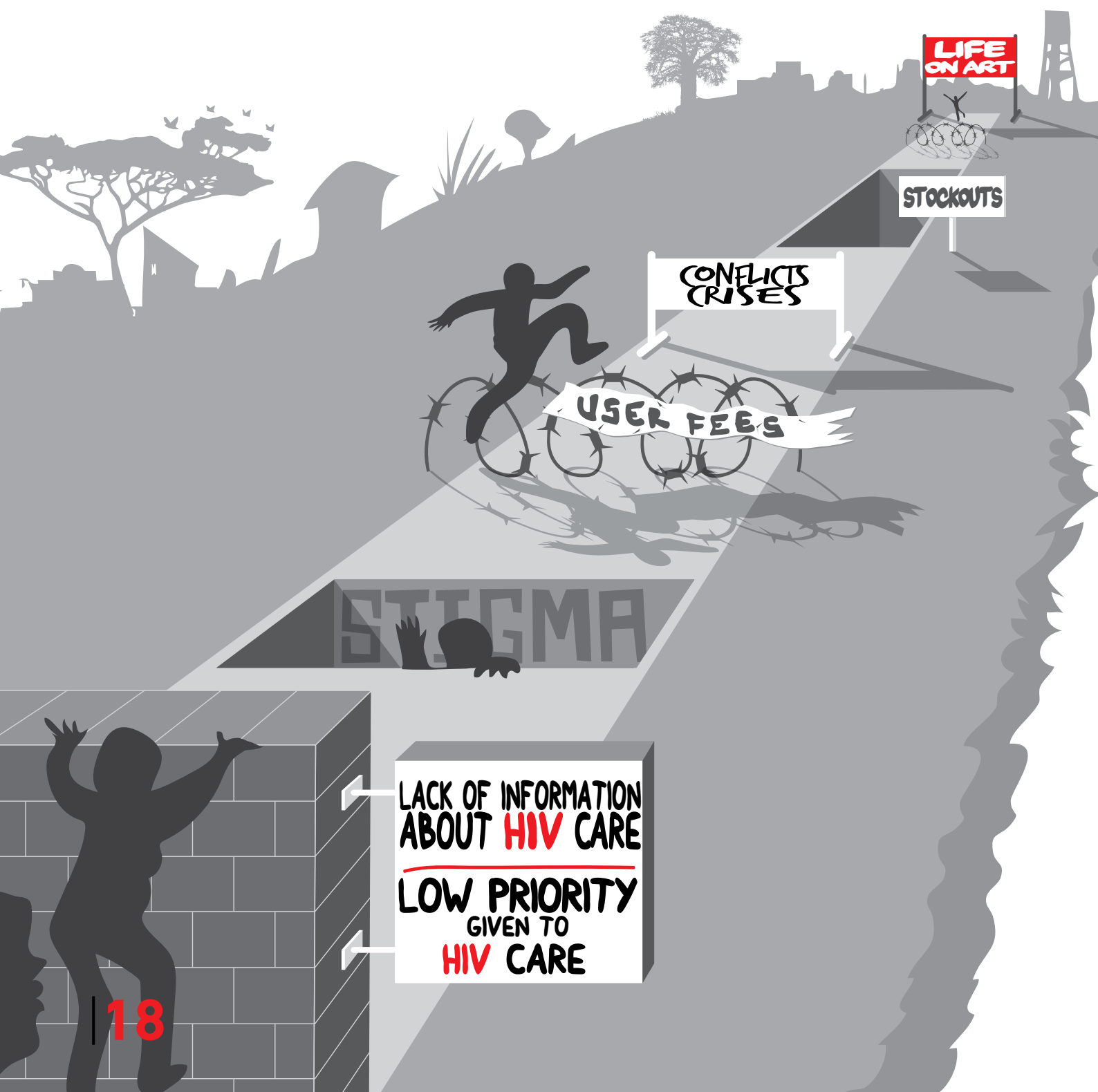
51 Walton DA, Farmer PE, Lambert W, *et al.* Integrated HIV prevention and care strengthens primary health care: lessons from rural Haiti. J of Pub Health Policy, 2005. See also: MSF. Increasing access to antiretroviral care in rural Malawi. 2009. Available from: <http://fieldresearch.msf.org/msf/bitstream/10144/116359/1/Bemelmans%20et%20al%20Universal%20access%20Thyolo%20TMIH.pdf>

52 Case A, Paxson C. The impact of the AIDS pandemic on health services in Africa: evidence from the demographic and health surveys. Working Paper: Princeton University 2008. Available from: <http://www.nber.org/papers/w15000>

53 MSF, Increasing access to antiretroviral care in rural Malawi. 2009. *Op.Cit.*

54 MSF, Punishing success? Early signs of a retreat from commitment to HIV/AIDS care and treatment. 2009. Available from: <https://www.msfaccess.org/our-work/hiv-aids/article/899>

3. REASONS FOR DELAYS IN IMPROVING ART COVERAGE IN WCA



While conflict and political instability impede continuity and scale-up of HIV programmes, these crises worsen important pre-existing difficulties for PLHIV in accessing adequate care. Many existing constraints result, directly or indirectly, from limited political will, weak health systems and little leverage to improve access to quality treatment.

Logic would suggest that countries with lower prevalence, and therefore lower caseloads of PLHIV, should be better able to cope. But this logic does not hold true in the majority of WCA countries. As in other countries with low HIV-prevalence, ART coverage results are lower⁵⁵. In the majority of WCA countries, lack of prioritisation from both policy makers and donors have led to programmatic, operational and structural challenges which prevent many countries from providing necessary HIV services. Mobilising resources to provide ARVs and comprehensive care for PLHIV competes with other health priorities. Likewise, civil society groups, so successful in rallying support within high-prevalence HIV countries, have a weaker voice and less leverage, as they represent a more marginalised group. Additionally, the humanitarian response to crises fails to give sufficient attention to HIV or measures to mitigate the vulnerable status of PLHIV.

3.1 LOW VISIBILITY, HIGH STIGMA AND DISCRIMINATION

HIV's low visibility in WCA leads to denial and neglect, thus hampering effective mobilisation and action. High levels of stigma and discrimination exist towards PLHIV, as reported by many patients in countries where MSF works. This can be attributed to a lack of media attention as well as misinformation and lower community involvement, but is also due to cultural and religious factors. In addition, although most WCA countries have laws protecting PLHIV, many have not yet been implemented.

Health workers and health facilities are not exempt from problems of stigma and discrimination. Due to unreliable confidentiality within health facilities, patients are often reluctant to seek HIV treatment near home. In Conakry, 20% of patients receiving ART in MSF-supported clinics come from rural areas outside the capital. The reasons for this cited by patients relate to lack of services, but also their lack of confidence in existing services, and, critically, anonymity.

Stigma also limits the power of civil society: patient groups remain small, with limited leverage to demand better care from the authorities and from donors. Patients end up feeling isolated and lacking peer support. Certain population groups – including sex workers, men who have sex with men, transgender people⁵⁶, prisoners and people who inject drugs – are disproportionately affected by HIV and face major difficulties accessing adequate care. Yet, mobilizing such marginalized groups is possible, as illustrated in the mining town of Kimbi, DRC, where more than 700 sex workers are involved in the HIV response, some of whom have helped MSF reach others in this high-risk group.

⁵⁵ Andrew Hill *et al.*, *Op. Cit.*

⁵⁶ According to a recent report, lesbian, gay, bisexual, transgender, and queer (LGBTQ) people across West Africa are increasingly living in a hostile environment. For more, see: Arminsen M., *We Exist : Mapping LGBTQ Organizing in West Africa*. March 2016. Available from: <http://www.astraeaafoundation.org/news/360/60/We-Exist-Mapping-LGBTQ-Organizing-in-West-Africa/d,home-news>

"There was a time when I totally lost hope. My family, my four brothers, they have all abandoned me. At one point, my husband took the children and sent them away to the village. When I started to lose weight, he threw me out and he married another woman. While I was ill, people went to my house and took everything, believing that I was going to die. It was so traumatic that I had a relapse. So when my health comes back, I'm going to put myself together well and no one will know that I've got HIV. I spent all my money on health centres and hospitals. When all the cash ran out, the centre threw me out, saying: 'Go home, you're going to die'. A doctor said they couldn't just let me die like that, so they brought me to MSF's Kabinda hospital. If I hadn't come, I would have died".

Patient, 37, Kinshasa, DRC

PLHIV in lower-prevalence contexts do not rank high on the priority list for support from international funders, which tend to concentrate on high-burden countries and highly concentrated pockets of epidemics within countries, resulting in the neglect or oversight of countries with small or dispersed populations of PLHIV. The current policy convergence of the US *President's Emergency Plan for AIDS Relief* (PEPFAR), the Global Fund and UNAIDS may reinforce this, with priority going to the same geographical areas or population groups with high transmission. The bulk of the available means may be concentrated here to allow effective fast-tracking of the full range of preventive and curative activities. However, it is unclear what support will be guaranteed outside these 'hotspots' in order to provide PLHIV with continued care and the much-needed fast-tracking of the HIV response.



3.2 WEAK HEALTH SYSTEMS AND INADEQUATE SERVICE DELIVERY MODELS

While health expenditure has been rising in WCA countries, many health systems remain weak and health service provision remains inequitable, detached from the needs of the population and often ineffective. This is particularly true of those countries that are repeatedly exposed to crises of one kind or another, such as epidemics or conflict, as in CAR, DRC and Nigeria. In CAR, even prior to the onset of civil unrest in 2012, the health system was categorised as 'non-existent'⁵⁷ and in a state of 'chronic medical emergency'.⁵⁸ Twenty out of 25 countries in the region are classified as 'fragile states' by the Organisation for Economic Co-operation and Development (OECD), while eight are classified as 'challenging operating environments' by the Global Fund.⁵⁹

Weak and underfinanced health services result in the financial burden for healthcare being transferred to patients and families. Out-of-pocket payment from patients for health services have been shown to drive poverty, exclude populations from healthcare and result in poor quality health practices by underpaid healthcare workers.

Even if ARVs are mostly free of charge, additional fees are charged for consultations, HIV tests, laboratory exams and the prescription of drugs other than ARVs, including drugs for opportunistic OIs. CD4 counts can cost up to US\$30 per patient. Unaffordable to many, these costs can cause delayed, incomplete or sub-standard care. If hospitalisation is needed, costs multiply.

Patient payment requirements may result in unnecessary medical acts or inefficient service provision. Where payments for services support revenue for healthcare staff, the staff may be resistant to best practices aimed at reducing unnecessary consultations, reducing the frequency of ARV refills, and facilitating refills and follow-up outside the health facilities (for example, in the community or by peer groups).

Health facilities dependent on patient fees may be reluctant to implement 'free ART' schemes. Health workers may resort to introducing 'patient quotas' for

ART in order to keep consultation time in priority for patients paying full fees. This can create bottlenecks and limit the number of PLHIV able to start ART. Financial obstacles to care reinforce other social, economic and stigma-related barriers. As a result, HIV testing and initiation of ARV is delayed, adherence to treatment is undermined, and quality care is jeopardised.

Best practices and models of care which have proven effective in other settings have not yet been adopted or adapted by many WCA countries where ARV coverage is low.

Simplified protocols and drug regimens are available, but implementation does not keep up with the needs. While many countries in WCA are still in the process of rolling out the 2013 WHO guidelines on simplified protocols and drug regimens, guidelines to include 'Test and Treat'⁶⁰, which is treatment for all, were released in 2015.

Poor implementation of task-shifting policies is hindering decentralisation and offer of ART in health facilities closer to patients' home, although they are deemed the most relevant approaches. Task-shifting from doctors to nurses and to lay healthcare workers was implemented effectively in Southern African countries facing a shortage of skilled healthcare workers, and resulted in better outcomes overall for both patients and programmes. Task-shifting would allow a more rapid scale-up of HIV services, diminishing the loss to follow-up and enhancing adherence to treatment.⁶¹

Community service delivery is still underutilised in the region, despite the critical role it has played in improving adherence for patients under ART in other regions.^{62,63} Integration of HIV and TB services is the exception rather than the rule in WCA, and patients face multiple steps to obtain a combination treatment, while a one-stop point of care has been shown to improve quality of care and adherence.⁶⁴

No systematic routine viral load testing is available yet in most countries in WCA, even though it has become

⁵⁷ Mark Beesley, Health provision in the Central African Republic, 2012.

⁵⁸ MSF. Central African Republic: A State of Silent Crisis, November 2011. Available from: http://www.msf.org/sites/msf.org/files/old-cms/fms/article-documents/A_State_of_Silent_Crisis_EN.pdf

⁵⁹ As of March 2016, these eight 'challenging operating environments' of the WCA region are the following: Burundi, CAR, Chad, DRC, Guinea Bissau, Mali, Niger, and Nigeria. Source: The Global Fund in Challenging Operating environments: the challenging operating environments policy. Draft Policy Paper, February 2016.

⁶⁰ In September 2015, WHO released a guideline that made two recommendations: First, that antiretroviral therapy (ART) should be initiated in everyone living with HIV at any CD4 cell count. Second, the use of daily oral pre-exposure prophylaxis (PrEP) is recommended as a prevention choice for people at substantial risk of HIV infection as part of combination prevention approaches. For more, see: <http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en/>

⁶¹ MSF. HIV/TB counselling: Who is doing the job? Time for recognition of lay counsellors, August 2015. Available from: http://www.msf.org/sites/msf.org/files/final_web_counsellor_report_one_page.pdf

⁶² Bemelmans M, Baert S, Goemaere E, et al. Community-supported models of care for people on HIV treatment in Sub-Saharan Africa, TMIH, August 2014. Available from: <http://onlinelibrary.wiley.com/doi/10.1111/tmi.12332/abstract>

⁶³ Ford N., Effect of frequency of clinic visits and medication pick-up antiretroviral therapy outcomes: a systematic review and meta-analysis. WHO presentation at ICASA, Harare, November 2015.

⁶⁴ Jochims F et al., Closing the gap: Decentralized, patient-centred and integrated TB/HIV care in a rural region in Swaziland. IAC Vienna, 2010.

the gold standard for ART monitoring because it allows the identification of patients in need of targeted support to improve adherence and treatment failure.

The failure to provide all components of comprehensive and continuous care risks worsening quality of care and increasing the loss to follow-up of patients, leading to possible treatment failure. This was documented by MSF in Bukavu, DRC, where more than one-third of all patients were lost to follow-up after MSF handed over to another agency; the patient care offered was no longer including free treatment for OIs, laboratory testing, home-based care, long-term refill of ARVs and nutrition support.⁶⁵ Similar problems have been described after treatment disruption in Lubumbashi, DRC when a national NGO had to halt HIV-service provision and patients had to find care in other health facilities.⁶⁶

Paediatric ART guidelines recommend treatment for all HIV+ children under the age of 5, yet these guidelines are not implemented, resulting in low treatment coverage. Many of the factors are similar to those causing low adult ART coverage, but there are additional problems, including: a lack of early infant diagnosis to detect HIV infection among HIV-exposed infants; loss to follow-up of mother-baby pairs during PMTCT; a lack of paediatric ARV formulas; low capacity and numerous missed opportunities to identify HIV-infected children.

Frequent shortfalls and stockouts of medical supplies hinder effective and efficient HIV health service provision. Weak supply systems result in over and understocking, as well as stockouts of drugs, equipment and other commodities (ARVs and OI medication, HIV tests, lab reagents).

Inadequate planning in funding proposals and supply plans, the slow disbursement of international funding, and delays in international orders can all create problems with supplies. This can be exacerbated by weak management in-country leading to poor reactivity to orders, and delays in supplies being transported to health facilities. Often, “last-mile delivery” to reach the health facility is neglected, and low stocks are not reported or acted upon in time. The logistics of supply chains are often managed by already overburdened medical staff with limited capacity to do so. All of these factors contribute to poor services and eventually worse health outcomes for PLHIV.

The existence of substantial stockout risks⁶⁷ and their impact on patients is often underestimated. Even if sufficient medical supplies are available at the central level, shortfalls and stockouts at the health facility level hamper new intakes and retention of patients, and can lead to viral resistance and negatively impact survival⁶⁸. In a 2014 survey carried out in Kinshasa, DRC, up to 77% of health facilities visited reported stockouts of at least one ARV during the previous three months. In addition, stockouts of test kits over a three-month period resulted in an estimated 4,000 patients not being tested at their request. Although most of the commodities were available at central level, the stockout resulted in 68% of PLHIV being sent away without the necessary medication.^{69 70}

Poor supply impacts the ability of countries to implement WHO’s updated treatment guidelines for PLHIV and to scale up early initiation. The treatment continuity that patients need to suppress the HIV virus is challenged. Changes to new regimen guidelines also bring challenges in supply continuity. Concerns about sufficient ARVs at country level also hamper efforts to extend the length of time between drug refills.

In most settings, MSF provides complementary drugs for OIs, HIV test kits and other medical commodities to cover the shortages. In Mali, MSF provides paediatric ARV in case of shortfalls. In some cases, as in DRC and CAR, MSF also has to cover for ARV shortages. In other cases, MSF is one of the main providers of ARVs at country level. In Guinea for instance, MSF provided almost 25% of all ARVs in the country in 2014.

65 MSF Briefing Paper: Bukavu HIV Case Study: Ongoing access to HIV care in Bukavu, MSF 2010.

66 Freeman A. et al. Patient Outcomes in Lubumbashi, Democratic Republic of Congo After a Disruption in HIV Care Due to Decreased Global Fund Appropriations. *AIDS Behav* (2014) 18:2135–2143

67 Gallien J. et al. National Drug Stockout Risks in Africa: Analysis of the Global Fund Disbursement Process for Procurement, March 2015

68 Pasquet A, Messou E, Gabillard D, Minga A, Depoulosky A, et al. (2010). Impact of Drug Stockouts on Death and Retention to Care among HIV Infected Patients on Combination Antiretroviral Therapy in Abidjan, Côte d'Ivoire. *PLoS ONE* 5(10).

69 MSF, Empty Shelves, come back tomorrow. ARV stockouts undermine efforts to fight HIV, November 2015. Available from https://www.msf.org/sites/msf.org/files/msf_out_of_stocks_.pdf

70 *Ibid.*



"We sometimes run out of HIV tests at hospital level, in which case we need to send people back home even when we suspect they're HIV positive. Considering the high levels of stigma in DRC many will be too afraid to hear a possible positive result and will never come back. They're lost to follow up even before having a chance to know their status".

Pierre Bilabi Butabambe, director of nursing, Mbankana hospital, Kinshasa.



"Stockouts are extremely frustrating. Because of stigma it's very difficult to convince people to get on ARVs, and once they're adherent we have to tell them that there are no medicines available. What can they think of this? It angers me".

Bijou Luboya Mudimba, nurse in charge of pharmacy, Bomoto health centre, Kinshasa.



"When my ARVs were out of stock I could only take Cotrimoxazole to avoid opportunistic infections. During that period, I had fevers and pains and lost five kilograms. I had to take sick leave from my job when the symptoms became unbearable".

Patient on ART, Kinshasa.

Necessary laboratory services are lacking, with negative consequences on access and quality of care.

Although in the future ART will be initiated regardless of a patient's CD4 count, as recommended under WHO's 'Test and Treat' guidelines, at present a lack of CD4 testing leads to delayed ART initiations, long waiting periods and loss to follow-up of patients. Lack of polymerase chain reaction (PCR) testing leads to late identification of infection in HIV-exposed babies.⁷¹ Many MSF programmes in WCA have to send their samples out of the country (for example, to South Africa) in order to get reliable and more timely early infant diagnosis results.

Monitoring of HIV-related information is weak, especially at the level of the user.

As a result, there are data gaps, questions about the validity of existing data and a lack of quality of available data, all of which hamper adequate planning, monitoring of progress and identifying the need for programmatic adaptation.

⁷¹ Routine HIV test detects the presence of antibodies to the virus. In infants, the remaining antibodies of the mother can give false positive results. Therefore, a specific PCR test that detects the presence of the virus itself is necessary.

3.3. LIMITED SUPPORT ROLE OF CIVIL SOCIETY

Community leadership and engagement are crucial in building demand as well as in delivering services that are responsive to local needs. Globally, PLHIV and civil society groups have through advocacy and activism significantly contributed to making HIV prevention and treatment affordable and available. These groups also support the uptake of and adherence to HIV treatment, and protect the human rights of the population groups most affected by the epidemic.⁷² In many low-prevalence countries, this movement is still in its infancy.

In addition, civil society groups have been disproportionately hit as international donors identify new priorities, or render countries that transition to a middle-income country status ineligible for international support. Many non-government organisations (NGOs) concerned with protecting the rights of PLHIV have seen a decrease in funding, further limiting their ability to support PLHIV and positively influence policy. Some had to scale down or stop activities altogether. For instance, since the World Bank ended support to the HIV projects in CAR in 2012, civil society associations of PLHIV have been struggling to survive.

In low-prevalence countries, it can be harder for PLHIV to organise themselves to take action, as often they are highly dispersed or concentrated in marginalised sub-groups of the population. This limits the power and pressure that patient groups can bring to bear on authorities, and can hamper the organisation of support services such as peer groups, counselling for initiation and adherence tracing of patients.

Additionally, the fragmentation of civil society organisations into distinct language-speaking groups (primarily English and French) leads to constraints in exchanging experiences and support between countries.

Yet mobilisation is possible as illustrated here :

Albert (photo below) is the 55-year-old president of an MSF peer support group in Bukavu, South Kivu, DRC. He first fell ill in 2008, with a cough and a lesion on his lip for which he received medication. A week later he fell into a coma and was admitted to intensive care at the MSF supported hospital in Baraka. He remained unresponsive for three days. During this time he was tested for HIV as doctors searched for a diagnosis. Albert can now be found almost daily at the hospital and often visits patients who are not attending their consultations in an attempt to encourage them to re-engage with care. He says: *"People don't understand HIV. They have a fear of taking the test because they think that if it's positive, they will die straight away."* In an attempt to improve public understanding of HIV, he recently shared his story in a busy local market. A theatre and dance group had drawn a large number of people and during a break in their show, Albert proudly addressed the crowd and explained his condition.



⁷² UNAIDS, Sustaining the human rights response to HIV: An analysis of the funding landscape and voice from community service providers, 2015. Available from: http://www.unaids.org/sites/default/files/media_asset/JC2769_humanrights_en.pdf

3.4 LOW PRIORITISATION OF HIV AND LACK OF POLITICAL LEADERSHIP

In WCA, there is a lack of political leadership for comprehensive HIV care packages. HIV's low visibility and low prevalence in these countries facilitate its political deprioritisation as one health problem among many. Such a view ignores the unique risks HIV poses to local populations and the specific measures needed to curb the epidemic in the region. In some cases, ambitious prevention and treatment objectives have been set, but for now exist primarily on paper. Financial investment in national HIV programmes remains weak at best, while policy to implement proven best practices lags behind countries where HIV prevalence is high.

Additionally, with the stagnation of development assistance for health in general, and with the downward trend in funding for HIV care in even high-prevalence countries, there is little international support to push the political leadership in WCA to implement adequate HIV care packages that could help the region reach the 90-90-90 goals. PLHIV in lower-prevalence contexts – especially when their populations are smaller or dispersed – do not rank high on the list for international support. Priority tends to be given to countries where the incidence rates or absolute numbers are seen as contributing more to the worldwide HIV burden.



3.5. DELAYED RESPONSE TO NEEDS OF PLHIV IN HUMANITARIAN CRISES

Conflict or humanitarian crises impede HIV services by delaying or interrupting the implementation of comprehensive HIV care and aggravating already weak health systems. They create loss to follow-up of patients on ART, disrupt care for the severely ill, make adherence more challenging, and disrupt or eliminate services that are already limited. When confronted with acute outbreaks of unrest, violence, displacement, epidemics or other crises, health facilities' supply chains break down and the necessary drugs and other medical commodities rapidly become unavailable. Health staff fails to come to work, and patients are deterred from travelling by security risks or transport difficulties. In the recent Ebola epidemic in West Africa, fear kept people away from health centres and HIV services were highly disrupted in the three high-transmission countries.

An analysis by civil society in Sierra Leone found that the Ebola epidemic weakened already inadequate supply systems, causing severely reduced access to ART services for PLHIV.⁷³ In Guinea, a study by the organisation Solthis documented a significant decrease in healthcare utilisation among HIV patients enrolled at Conakry's Donka hospital during the Ebola outbreak in 2014.⁷⁴ An estimated 42% of patients on ART were lost to follow-up. However, in existing MSF-supported HIV treatment sites in the capital a group of patients on a refill scheme with sufficient ARV quantities for three to six months showed higher rates of uninterrupted treatment during the Ebola outbreak.⁷⁵ (See Guinea case study.)

Evidence shows that HIV services can and should be maintained throughout crisis situations:

- The Inter-Agency Standing Committee (IASC) guidelines, revised in 2010, recommend the continuation of ART for those already on treatment prior to a crisis.⁷⁶ This should be considered a priority intervention and part of the minimum initial response to HIV, even during the acute phase of an emergency.

⁷³ ITPC, Ebola is a major factor interrupting antiretroviral treatment to people living with HIV in Sierra Leone, May 2015: <http://itpcglobal.org/itpc-west-africa-press-release-ebola-is-major-factor-interrupting-antiretroviral-treatment-to-people-living-with-hiv-in-sierra-leone/>

⁷⁴ Ndawinz J., Cissé M. et al., Prevention of HIV spread during the Ebola outbreak in Guinea, *The Lancet*, Vol. 385, Issue 9976, 1393, April 2015. Available from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)60713-9/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60713-9/abstract)

⁷⁵ Ortuna R. et al. (2015). ARV Provision for Longer Periods in Guinea Improves Retention in Care, Including during the Ebola Crisis. Abstract: 1958. Oral presentation at ICASA conference, Harare, November 2015.

⁷⁶ IASC Taskforce on HIV in Emergencies. Guidelines for addressing HIV in humanitarian settings, September 2010, available from: <http://interagencystandingcommittee.org/node/2870>

- Similarly, the UNHCR has developed guiding tools regarding the delivery of ART to migrants and crisis-affected PLHIV in sub-Saharan Africa.⁷⁷
- A UNAIDS board meeting in 2015 reiterated the need to prepare for appropriate HIV interventions at all stages of a humanitarian emergency as well as to integrate disaster/emergency preparedness planning routinely into all HIV programmes.⁷⁸

Experience has shown that preparation and contingency provisions can significantly mitigate the consequences of disruption of services. However, this has not translated into policies or action where it is most needed:

- HIV services are still wrongly perceived as complex by aid agencies and/or emergency teams, with other interventions seen as more urgent. ARVs are often not included in the first delivery of medical supplies.
- Displaced populations are particularly affected. With a record number of people displaced by conflict and violence today (59.5 million in 2014 according to UNHCR), it is crucial to ensure continuity of care and supply of ARVs, as well as other necessary medical

- supplies in crisis situations, such as the recent crises in Ivory Coast, DRC and CAR. In the latter, a 2013 mapping exercise conducted by UNHCR concluded that many people receiving ART were forced to flee as a result of conflict and this led to discontinuation of HIV treatment for many, due to the lack of functional health services in the remote places to which they fled.⁷⁹ Yet, some agencies still actively resisted the HIV contingency plan that would, among other things, provide patients with three months' supply of ARV refills in case of another or repeated emergencies.⁸⁰
- Reluctance to initiate ART during crises – in spite of clear evidence in favour of starting ART early – still persists. With displaced people at a higher risk of HIV infection – including through sexual violence and increased vulnerability – such early initiation should be encouraged and supported as an essential component of the expanded humanitarian response.

COMMON PROBLEMS AND BARRIERS TO HIV TESTING, TREATMENT AND CARE IN WCA

PATIENTS ASKED TO PAY

- Services unaffordable for many
- Patients excluded or deterred from timely consultation
- Poor quality of care received

PATIENT-UNFRIENDLY SERVICES

- Strategies not patient-based, nor results-centred
- HIV treatment embedded in weak or inequitable health systems, hence weak results

SERVICE DELIVERY MODELS

- Effective strategies not applied
- Non-optimal use of existing HIV care services – including those provided by religious networks and NGOs

POOR ACCESSIBILITY OF SERVICES

- Financial
- Geographical
- Long waiting times
- Stigma and lack of confidentiality
- Lack of targeted facilitation of services for key populations

NATIONAL TARGETS

- Political will and (national & international) priority lacking

SUPPLY CHAIN

- Insufficient and irregular supply of commodities
- Frequent and long lasting stockouts of lab tests, ARVs and drugs to treat opportunistic infections, that jeopardise continuity of care and interrupt ART initiations
- Lack of financial and logistical support for in country supply chain and last mile delivery to health facilities

CRISIS SITUATIONS

- In emergencies, HIV is not prioritised by NGOs or UN agencies
- Contingency plans are not in place

FUNDING

- Strategies in funding & support are ill-adapted to 'fragile' contexts
- Available funding doesn't go to most effective ART delivery strategies and to innovative approaches
- Insufficient overall funding for HIV, especially for civil society groups and prevention activities

⁷⁷ UNHCR, Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Persons in Sub-Saharan Africa, September 2014, Available from: <http://www.unhcr.org/541fe8a19.pdf>

⁷⁸ UNAIDS. Promoting greater focus on HIV in humanitarian emergencies. July 2015. Available from: http://www.unaids.org/en/resources/presscentre/featurestories/2015/july/20150702_PCB36_thematic_

⁷⁹ UNHCR, HIV/AIDS: Conflict in Central African Republic disrupts treatment, September 2014: <http://www.unhcr.org/540716716.html>

⁸⁰ Contingency plans also include buffer stocks at clinic level, community involvement for ARV distribution, updated booklets with information for patients – including guidance regarding other HIV services available, coordination between HIV stakeholders regarding patient referral possibilities, etc.

4. ALLOCATION AND MOBILISATION OF RESOURCES

GLOBAL HIV FUNDING

In 2014, global spending on HIV was US\$20.2 billion, representing a slight decrease from 2013, after more than a decade of increasing funding for the global HIV response.⁸¹ It was also still short of the 2011 Political Declaration on AIDS which called for US\$22-24 billion annually by 2015.⁸² Domestic resources constituted more than half of the available resources in low and middle-income countries, driven mainly by countries such as Botswana, Namibia and South Africa.⁸³ However, in 44 low and middle-income countries, more than 75% of HIV financing comes from international donor funding.⁸⁴

By 2020, UNAIDS estimates that US\$31.1 billion will be required annually worldwide, of which at least 40% should come from international sources.⁸⁵ The full implementation of WHO's newest guideline to treat all PLHIV and the 90-90-90 goal is dependent on additional resource mobilisation.⁸⁶ Moreover resources will have to be directed increasingly to care and treatment – and in particular ART.⁸⁷

While UNAIDS estimates that sustaining current HIV efforts from 2014 to 2030 will require up to 2% of GDP and at least one-third of total government health

expenditure in the most affected African countries,⁸⁸ the current reality in many countries falls far short of this. The ability to mobilise additional domestic resources depends critically on political will and restrictions on public spending. It is also likely to be impacted by volatile economic perspectives in sub-Saharan Africa caused by a number of factors, including global prices of oil and other minerals, drought or the slowing down of the world economy.⁸⁹

Since 2010, international donor funding increases have levelled off and in 2014 donor government disbursements for HIV grew by a modest 2% to US\$8.64 billion. While the US government's contribution has flat-lined at US\$5.6 billion in 2014, it remains the largest donor, providing nearly two-thirds of donor funds for HIV.⁹⁰ Other donor countries have shown a preference to provide HIV/AIDS funding through multilateral channels, including the Global Fund.⁹¹ Overall contributions to the Global Fund for the 2014-16 period increased after the Global Fund went through significant reforms.⁹² With donors such as the World Bank and several bilateral funders withdrawing from HIV, and in particular from ARV funding, the Global Fund plays an increasingly important role in the ARV market, taking on about a third of ARV purchasing.

81 ONE, Unfinished Business: tracking global commitments on AIDS, vol. 4, December 2015 <http://one.org.s3.amazonaws.com/images/AIDS%20Report%202015%20-%20English.pdf>

82 UNAIDS Fact-Sheet 2015. Available from: http://www.unaids.org/sites/default/files/media_asset/20150901_FactSheet_2015_en.pdf

83 UNAIDS, How AIDS changed everything. UNAIDS; Geneva 2015 (MDG6 report). Available from: http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf

84 ONUSIDA, Fiche d'information 2015, *Op.Cit.*

85 UNAIDS, 2016-2021 Strategy. On the Fast-Track to End AIDS. Available from: http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

86 *Ibid.*

87 Granich R. *et al.*, Pattern, Determinants, and Impact of HIV Spending on Care and Treatment in 38 High-Burden Low- and Middle-Income Countries. *J Int Assoc Provid AIDS Care*. 2016;15(1). Available from: <http://www.iapac.org/uploads/JIAPAC-Granich-et-al-HIV-Spending-Analyses-Pre-Print-120115.pdf>

88 UNAIDS, How AIDS changed everything, *Op.Cit.*

89 Rowden R., Africa's boom is over. Rick Rowden. *Foreign Policy*, December 2015. Available from: <https://foreignpolicy.com/2015/12/31/africas-boom-is-over/>

90 The Henry J. Kaiser Family Foundation and UNAIDS, Financing the response to HIV in low and middle income countries: international assistance from donor government in 2014. July 2015. Available from: <http://kff.org/global-health-policy/report/financing-the-response-to-aids-in-low-and-middle-income-countries-international-assistance-from-donor-governments-in-2014/>

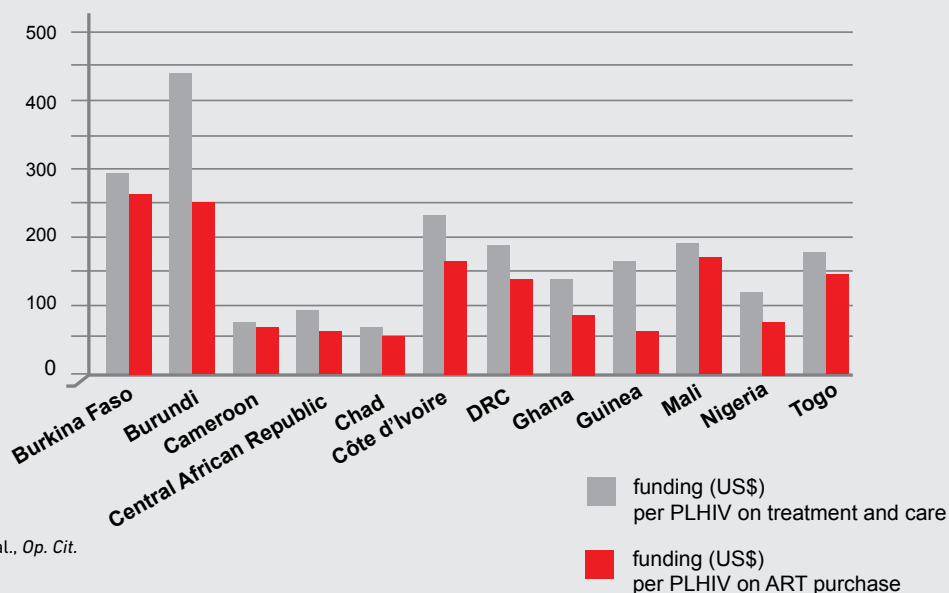
91 Overall the proportion of multilateral funding has increased over time, rising from 24% in 2006 to 27% in 2014. When excluding the US government, the proportion of multilateral contributions rose from 29% to 47%. Source: The Henry J. Kaiser Family Foundation and UNAIDS, *Op. Cit.*

92 *Ibid.*

In 12 countries of West and Central Africa for which data are available, total (adjusted) HIV spending on care and treatment per person living with HIV differs widely, from US\$65 (Chad) to US\$436 (Burundi). See figure 6 for details. Six out of these 12 spend less than US\$100 on

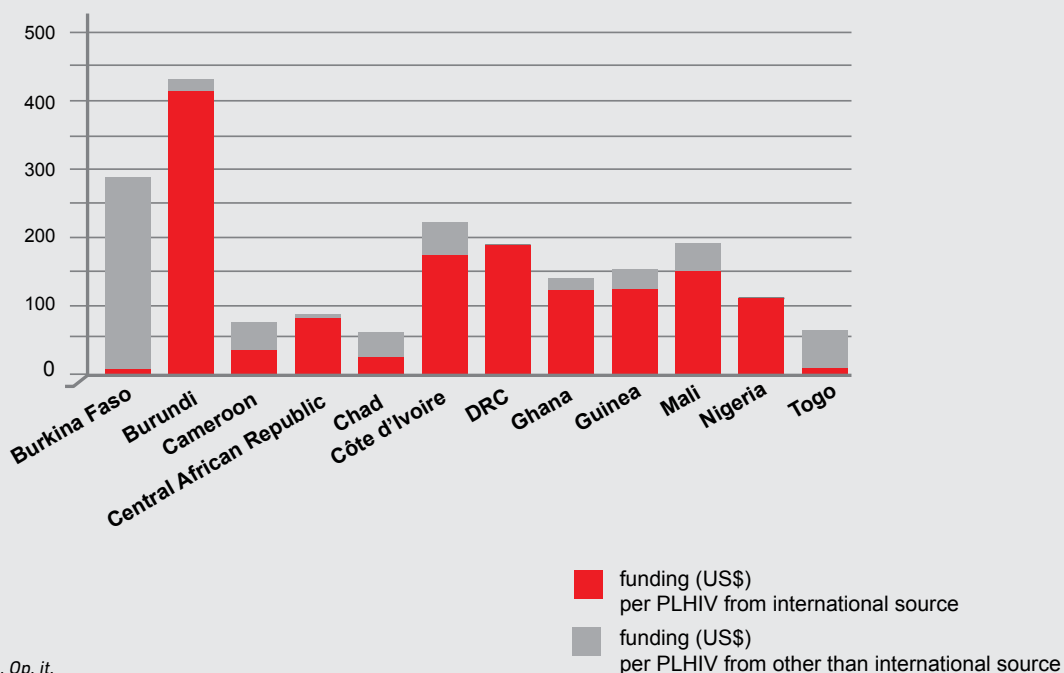
ART per PLHIV. Only in Burundi over half of resources for HIV go to care and treatment. For eight countries, more than 75% of funding for care and treatment comes from international sources (Figure 7).

Figure 6 :
Total funding (domestic and international) spent per PLHIV on HIV treatment and care and on ART purchase in selected countries of WCA. Financial data from 2011-2013.



Source: Granich et al., *Op. Cit.*

Figure 7 :
Amount spent by international and other sources on treatment and care per PLHIV in selected countries of WCA



Source: Granich et al., *Op. it.*

4.1 DOMESTIC RESOURCES IN WCA

In WCA, the proportion of total HIV expenditure from domestic sources ranged in 2012 from 1% to 64% of current HIV expenditure.⁹³ Without significant international support, ensuring sufficient sustained funding for HIV remains a concern. From domestic resources in DRC, Nigeria and CAR, for example, less than US\$10 per PLHIV went to treatment and care in 2012.^{94,95} Only three out of 12 countries in WCA spent more than one in four dollars in HIV spending on the purchase of ART.

According to UNAIDS, countries classified as middle income are expected to increase their domestic contribution to cover between 45 to 95% of total funding needs for their HIV responses.⁹⁶ However, gross national income is a poor predictor of government health expenditure capacity and only weakly correlates to HIV spending on care and treatment.⁹⁷ In countries such as the Republic of Congo, Mauritania and Gabon, volatile annual gross national incomes do not necessarily reflect their governments' ability or preparedness to provide health or HIV services.

In addition, while domestic resource mobilization aims to foster increased public spending, the pressure to

increase domestic funding could lead to policies that increase out-of-pocket expenses for patients in contexts where most people live below the poverty line. In several countries, such as Kenya, Zimbabwe, Malawi or Mozambique, the prospect of reduced donor funding has re-opened discussions on reintroducing or expanding user fees. This is a considerable risk to universal and equitable access to treatment, particularly in the WCA region, where patient fees already represent one of the main barriers to care. Out-of-pocket expenses from households constitute an important part of resources spent on HIV in WCA. In DRC for instance, households contributed 38% of all HIV expenditure through out-of-pocket payment in 2012⁹⁸ and in Nigeria, they contributed 31%. Payment for HIV services takes up 14.5% of annual household expenses in Nigeria, representing a clear risk for further impoverishment.^{99,100}

A critical review of existing resource strategies and priority allocations could increase effectiveness and efficiency, mainly by ensuring that resources are used optimally to benefit PLHIV, in particular those at risk of being left behind. However, efficiency gains alone will not fill the financing gap.

⁹³ WHO Global Health Expenditures database: <http://apps.who.int/nha/database/>

⁹⁴ Rapport sur l'état d'avancement de la réponse à l'épidémie de VIH/SIDA (2014). PNMLS, Mars 2014. Kinshasa, RDC. With reference to REDES report 2011-2012.

⁹⁵ Granich R. *et al Op.Cit.*

⁹⁶ UNAIDS, On the Fast-Track to end AIDS, *Op. Cit.*

⁹⁷ Granich R. *et al Op.Cit.*

⁹⁸ Rapport sur l'état d'avancement de la réponse à l'épidémie de VIH/SIDA (2014). PNMLS, Mars 2014. Kinshasa, RDC. With reference to REDES report 2011-2012.

⁹⁹ National AIDS Spending Assessment (NASA) for 2011-2012. Federal government of Nigeria. Available from: http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/data-and-analysis/tools/nasa/20141017/nigeria_2011-2012_en.pdf

¹⁰⁰ Onwujekwe O. *et al.* (2016). Examining geographic and socio-economic differences in outpatient and inpatient consumer expenditures for treating HIV/AIDS in Nigeria. *J.Int AIDS Soc.* 2016; 19(1): 20588. Published online 2016 Feb 1. doi: 10.7448/IAS.19.1.20588. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4737733/>



4.2 INTERNATIONAL ASSISTANCE

As discussed above, donor agencies have showed limited interest in HIV in WCA. HIV investments are often seen as programmatically complicated to implement and difficult to manage for governments short on the resources and technical capacity needed to sustain long-term efforts. From a purely development perspective, saving lives by providing ARVs is often considered insufficient to justify these investments. Outside of an acute humanitarian crisis, the existing treatment gap rarely qualifies for emergency funding.

Historically, WCA has had relatively few PEPFAR-focused countries, and currently PEPFAR has only four priority countries within WCA: Cameroon, Ivory Coast, DRC and Nigeria. The Global Fund tends to be the major – and often the only – donor that funds HIV activities in WCA countries, particularly the provision of ARVs. The World Bank and many European donors have now shifted from financing AIDS treatment and service delivery activities to supporting health systems with capacity-building, technical assistance, consultancies and one-off investments.¹⁰¹ The World Bank has ended its specific HIV treatment funding (known as TAP/MAP), while UNAIDS¹⁰²

has phased out the purchase of paediatric and second-line ARVs. In spite of the significant gap in terms of HIV services and financing, many development donors are reluctant to invest in recurrent costs related to HIV treatment, such as staff salaries.

The reliance on Global Fund grants alone creates a potentially precarious situation. Without alternative sources of funding, any disruption in the institution's grant disbursement can have serious consequences for country programmes. Additionally, there are too few stakeholders available to fill the remaining funding gaps in the HIV response. The Global Fund runs a register of countries' funding requests that have been assessed by its independent Technical Review Panel as strategically focused and technically sound, but for which there were not enough funds at the time of application. This register of "Unfunded Quality Demand" serves as an inventory of critical components in need of funding, but only accounts for a part of the funding gaps in countries' HIV responses. Table 2 shows quality components listed on the register from selected WCA countries, for which other sources of funding are sought.

Table 2 :
WCA funding requests for critical HIV interventions listed on the Global Fund
'Unfunded Quality Demand' (UQD) register (in Million, US\$)¹⁰³

Country	ART	PMTCT	HCT	HSS/CSS	Prevention	HIV/TB	Other*	Total UQD
Cameroon	\$10.54 M		\$4.69 M					\$15.23 M
Congo (Republic of)		\$0.05 M	\$0.83 M	\$0.80 M	\$1.18 M	\$0.13 M	\$0.38 M	\$3.37 M
Gambia	\$5.62 M	\$1.06 M		\$0.05 M	\$0.76 M		\$0.36 M	\$7.85 M
Ghana	\$3.47 M			\$1.24 M	\$1.67 M			\$6.38 M
Guinea	\$7.45 M	\$5.15 M				\$1.10 M		\$13.70 M
Nigeria	\$48.02 M				\$9.15 M	\$11.06 M		\$68.23 M
Sierra Leone	\$5.90 M			\$4.08 M	\$4.00 M	\$0.97 M		\$14.95 M

¹⁰¹ No Time to Quit: HIV/AIDS treatment gap widening in Africa. Médecins Sans Frontières 2010. Available from: <http://www.doctorswithoutborders.org/sites/usa/files/MSF-No-Time-to-Quit-HIV-AIDS.pdf>

¹⁰² UNAIDS is a global health initiative in great part financed by a solidarity levy on airline tickets.

¹⁰³ Global Fund Register of Unfunded Quality Demand (as of 29 of January 2016)
http://www.theglobalfund.org/documents/core/grants/Core_UQD_Tool_en/

4.3 CIVIL SOCIETY SUPPORT UNDER STRAIN

Funding reductions for civil society organisations, including patient/PLHIV associations, are another worrying consequence of overall limited funding. While recognised as key to HIV diagnosis, treatment and care, these organisations now face difficulties. According to UNAIDS, 59% of HIV-related civil society organisations worldwide reported decreases in funding in 2014.¹⁰⁴ Domestic funding for non-governmental organisations (NGOs) is often volatile, with the risk that selection criteria will depend on an NGO's political alignment, which impedes their capacity to challenge government policies and practices. Nearly 70% of organisations reported that they had never accessed domestic funding.¹⁰⁵ This is in stark contrast to the UNAIDS recommendation that countries' HIV services provision through community organisations should be increased from 5% to 30% in order to reach the 90-90-90 targets.¹⁰⁶

4.4 FRAGILE SYSTEMS AND WEAK MANAGEMENT

The overall shortfall in HIV funding in WCA is compounded with a less than optimal use of available funds. As mentioned earlier, 20 WCA countries are classified as fragile states by OECD, with low absorption capacity, high volatility and a high financial risk for international funding, including for HIV. Slower or lower results compared to more developed and stable countries might be explained by the difficult context, but progress is also hampered by a vicious circle of weak performance or reporting, leading to restricted funding allocations, followed by even lower results. Financial risks are often met with stricter conditions of disbursement, which in turn slow down operations and the efficient use of available funds.¹⁰⁷

The Global Fund's new funding approach is supposed to be more flexible than previously, with grant management conditions adapted to each country's context. This represents an important opportunity for those countries in need of catch-up– but only if the funding allocations accommodate the need for scale-up at a faster pace.

Several countries in WCA are classified by the Global

Fund as 'challenging operating environments': countries, parts of countries or regions characterised by weak governance, poor access to health services and man-made or natural crises. To mitigate these challenges and improve results in these contexts, the Global Fund allows for more flexibility and better risk preparedness in grants, but in practice the application of such flexibilities has so far been limited.¹⁰⁸ For instance, the most recent Global Fund proposals submitted by DRC and Guinea are experiencing significant delays, due to new and more demanding application processes, which in turn contributed to delayed implementation and scale-up. Without sufficient support to remove administrative and procedural bottlenecks, DRC and Guinea risk not meeting their targets by the end of 2017. In CAR, scale-up rates are exceeding current targets but without additional investments, such fragile gains may be lost.

4.5 RESPONDING TO HIV IN HUMANITARIAN CRISES

As discussed previously, HIV services are still not systematically provided in acute humanitarian situations. At best they are delayed to a later stage of the intervention.

Currently a number of agencies are exploring initiatives to adapt funding support to both fragile contexts and emergency situations. The review by the Global Fund¹⁰⁹ of its experiences in challenging operating environments highlighted the undervalued importance of taking operational risks related to not being able to realise the results expected, in contrast to the financial risks that dominate the discussions. Typically, risk-averse agencies will suspend interventions during humanitarian crises, while population needs for quality care – including HIV services – remain or even increase. The Global Fund's new Emergency Fund of US\$30 million was established to enable continuation of services during events that risk disruption of services. For instance, some of these funds were used to ensure continuity of HIV treatment following the earthquake in Nepal and the conflict in Ukraine.

The main challenge remains the flexible use of existing grants, adapting interventions and funding flows in response to changing needs. A shorter and more nimble planning cycle is key to remaining effective and adaptive to PLHIV in crisis situations.

¹⁰⁴ UNAIDS, Sustaining the human rights response to HIV: An analysis of the funding landscape and voices from community service providers. 2015. Available from: http://www.unaids.org/sites/default/files/media_asset/JC2769_humanrights_en.pdf

¹⁰⁵ *Ibid.*

¹⁰⁶ ONUSIDA, TDR Consultation régionale sur 90-90-90 avec les implémentateurs en Afrique de l'Ouest et du Centre, Dakar, novembre 2015.

¹⁰⁷ Solthis, Managing Risk in Fragile States: Putting Health First! Optimising the Efficiency of the Global Fund's Grants, November 2014. Available from: http://solthis.org/wp-content/uploads/2015/11/Solthis_GF_Risk-management_2014_report.pdf

¹⁰⁸ *Ibid.*

¹⁰⁹ TERG Position Paper: Thematic Review of the Global Fund in 'Fragile States'. Global Fund, 2013-2014.

WHAT CAN AND SHOULD BE DONE TO INCREASE ART COVERAGE?



- Create political pressure to mobilise around the 90-90-90 targets



- Fund strategies that work for patients and give better outcomes



- Tackle stigma and discrimination, educate patients and promote human rights



- Remove barriers posed by out-of-pocket payment and fee for services



- Implement task-shifting, including clinical training and support, for nurses, midwives and lay counsellors



- Simplify and improve laboratory testing



- Put in place proper supply chain management and ensure commodities effectively reach patients



- Ramp up HIV testing services at community level and for specific patients in health services



- Boost access to ART initiation by applying a 'treat all' principle



- Ensure that key populations are not left out



- Enhance PMTCT services with the 'test & treat' approach (B+)



- Drastically increase access to diagnostic and paediatric ARV formulations

5. WHAT CAN AND SHOULD BE DONE?

To improve their chances of survival, people with HIV need to start treatment early, before the virus has weakened their immune system. This will happen only when access to testing and treatment dramatically improves. Effective strategies to scale up early ART exist, but in many places they have yet to be applied. Innovative strategies are also needed to bring the ART revolution to the people of West and Central Africa. We present some possible solutions, based on experience from the region and elsewhere.

However, these strategies need to be adapted to the needs of the population in specific contexts. Strategies which work in high-prevalence countries – such as decentralisation and the systematic integration of ART services into existing health services – may not always be the best option for low-prevalence countries. When HIV patients are either dispersed or in low numbers, it can be difficult to find health workers with sufficient medical expertise to manage HIV programmes properly and provide adapted and adequate ART services to patients. It can also be more complicated in spread out sites to organise support measures that improve quality of care and adherence, such as peer support, tracing of latecomers, specific initiation and adherence counseling.

5.1. ENABLE EFFECTIVE POLICIES AND MODELS OF CARE

Certain policies have shown their effectiveness in improving offer and access to treatment for PLHIV and can in particular mitigate barriers in weak and inequitable health systems.^{110, 111}

Apply a strict no pay policy for PLHIV and HIV/TB services. In order to avoid financial barriers to initiation, continuation and quality of care offered, out-of-pocket payment and fees for services should be removed.

¹¹⁰ MSF and UNAIDS, Speed Up, Scale Up: Strategies, tools and policies to get the best HIV treatment to more people, sooner, July 2012. Available from: <http://www.msfasthiv.org/content/speed-scale-strategies-tools-and-policies-get-best-hiv-treatment-more-people-sooner>

¹¹¹ MSF, Reaching Closer to Home, October 2014. <http://samumf.org/download/reaching-closer-to-home-eng-pdf/>

This means:

- Patients should not pay for essential care and certainly should not be required to pay a second time for commodities and services that have already been subsidised. Specific attention needs to go to assuring access free-of-charge to drugs for OIs, CD4 counts, basic laboratory testing, consultation and hospitalisation fees.
- Enlisting the help of patient associations to monitor and report how effectively free HIV care policies are being applied.
- Exploring the possibility of providing patients with subsidized vouchers for free-of-charge services, in order to motivate underpaid staff to provide care that does not generate revenues.
- Providing all stable patients with ARV refills within the community, and at less frequent intervals, to counter unnecessary clinic visits driven by health staff's financial interests.

Task shifting can radically improve access to continued and quality care.

The current clinician-centred approach ignores the critical shortage of doctors that exists in some countries and in most rural areas in WCA.

- The latest WHO HIV testing services guidelines recommend task-shifting for HIV testing services to trained lay counsellors, who can use rapid diagnostic tests to independently conduct safe and effective HIV testing services.¹¹²
- The strategy of task-shifting to nurses has proven to be as good or even better for quality of care, as they are more likely to follow standard protocols. Countries in WCA have yet to fully implement this strategy.
- Further task-shifting to other cadres of staff contributes to rapid scale-up of HIV services as well as to enhanced adherence and follow-up of patients. MSF has previously highlighted the key role of lay counsellors in HIV/TB counselling.¹¹³

¹¹² WHO, Guidelines - HIV testing services ; WHO, Geneva, 2015

¹¹³ MSF, HIV/TB counselling: Who is doing the job? Time for recognition of lay counsellors, August 2015. Available from: http://www.msf.org/sites/msf.org/files/final_web_counsellor_report_one_page.pdf

- ARV distribution by peer and community members is also a key enabler. In many settings, MSF has achieved task-shifting through on-the-job training and mentoring of healthcare workers.

Improve and simplify laboratory testing.

The adoption of 'Treat all' will considerably alleviate the burden and cost of laboratory testing, since there will be less need for CD4 testing. Laboratory services should be reorganised in support of a simplified model of care. Approaches that can further simplify and improve testing include:

- Availability of laboratory tests can be improved by moving to rental options or using already existing platforms at point of care, for example GeneXpert, especially in rural areas.
- Increase use of routine viral load testing, which identifies early patients who fail treatment, and provide adherence counselling, helping to keep people on first-line treatment. Viral load testing also provides a means to monitor quality of care and allows fewer clinic visits for patients with viral load suppression and ARV refills for longer periods. MSF has introduced routine viral load testing in several places, including Guinea and DRC.
- The human resources constraints for the collection of samples can be alleviated through task-shifting. For example, MSF effectively used community workers to perform finger prick blood collection.
- Innovative methods such as M-Health¹¹⁴ and E-Health¹¹⁵ can also be used. They contribute significantly to reduction of time to notification of test results.

Implement robust and flexible supply chain management.

Frequent stockouts of ARVs, drugs for OIs, tests and other commodities are a huge barrier to providing quality HIV services. Their occurrence negatively impacts retention in care and may induce ARV resistance and the need for more expensive and less accessible second-line regimens. In addition, they create an additional burden on health care workers and patients. However, stockouts and their consequences on treatment incompleteness or failure to treat at all are rarely monitored.

To reach ambitious treatment initiation and retention targets, it is of utmost importance that an uninterrupted supply of all commodities is guaranteed. Effective supply chains, particularly in weak health systems, depend on accurate planning that includes anticipating potential problems, as well as predefined mechanisms for a rapid reaction to mitigate these problems.

¹¹⁴ According to Wikipedia, M-Health is 'an abbreviation for mobile health, a term used for the practice of medicine and public health supported by mobile devices'. (For more, see: <https://en.wikipedia.org/wiki/MHealth>)

¹¹⁵ According to WHO, E-health is 'the transfer of health resources and health care by electronic means'. (For more information, see: <http://www.who.int/trade/glossary/story021/en/>)

This can be done through:

- improved planning, forecasting and budgeting of required supplies; budgets towards complementary and nimble supply channels; limiting intermediate levels in stocking of commodities; improved information exchange and coordination among partners involved in the supply chain management system; financial and logistical support for transport and delivery to health facility levels (last mile delivery); sufficient buffer stocks at central and health facility levels; an effective alert system for quick response to low availability at health facility level; external verification through involvement of civil society through systems such as patient 'observatories'; improvement of current inadequate monitoring and evaluation tools with indicators reflecting real access for patients; adequate and updated contingency plans (including stocks for emergencies).

Tackle stigma and discrimination.

In low-prevalence countries in particular, stigma inhibits people from seeking timely care. It also limits the creation of patient associations and activism. Ways to tackle stigma include:

- Proactively supporting community mobilisation, as community leadership is crucial to minimise deterrent effects of stigma and discrimination.
- Ensuring access to legal aid services for PLHIV, key populations and other vulnerable groups.
- Specific interventions to limit stigmatising attitudes and practices in health services, for instance through involvement of PLHIV.



© Unknown Expat

PLHIV activists organizing a fashion show to raise awareness on HIV/Aids in Kinshasa, DRC.



Provide amplified and continued support to empower civil society groups.

Civil society groups can speak on the needs of PLHIV, reduce stigma and increase political demand for quality HIV services. Their input can improve planning and implementation of national strategies. They can monitor availability of services and improve accountability. In particular they have a key role in developing patient-centred services, community interventions, patient

literacy and autonomy.

- Non-state organisations – including NGOs, faith-based organisations¹¹⁶ and the private sector – are often underused and could play a greater role in the delivery of HIV services.
- Civil society and communities provide lay counsellors and other peers to improve access and quality of care in health facilities and provide early tracing of PLHIV who miss appointments.
- Community-based models of care critically depend on patient associations and civil society organisations to bring care closer to PLHIV.
- Patient associations can reduce stigma in the community and among health workers, and facilitate systematic investment in improved patient literacy and autonomy.
- ‘Observatories’ or patient groups can monitor quality and accessibility of services, answering questions such as: Is diagnosis and treatment really free-of-charge to patients and do healthcare workers respect the policy? Are ARVs, OI drugs and tests available in the health centre?

Encourage active knowledge and experience transfer on effective ARV delivery, by communicating positive experiences in Eastern and Southern Africa, and international literature in general.

For many countries in WCA this transfer of knowledge is currently limited by language barriers. A recent study estimated average ART coverage in Francophone countries in Sub-Saharan Africa at 26%, and in 15 of these countries both ART and PMTCT coverage were below the average for Sub-Saharan Africa.¹¹⁷ More systematic translation and dissemination of tools into French by stakeholders active in HIV would be of great help to the WCA region.

Encourage international reflection on more effective and innovative approaches in the WCA region.

Presently, few efforts are being made to identify game changers to ensure progress in these countries. Even within MSF, pilot experiences and radical new models of care are rarely applied. To reach 90-90-90 by 2020, some fundamental, innovative changes must be undertaken to tackle the problem. We need a proactive, dynamic collaboration on HIV in the region, supported by well-planned operational research and better documentation.

¹¹⁶ Kagawa RC, Anglemeyer A, Montagu D., The Scale of Faith Based Organization Participation in Health Service Delivery in Developing Countries: Systemic Review and Meta-Analysis. PLoS ONE 7(11): e48457. doi:10.1371/journal.pone.0048457, November 2012. Available from: <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0048457>

¹¹⁷ VIH/SIDA, tuberculose, paludisme et aide au développement en Francophonie. Amis du Fonds Mondial Europe. Janvier 2015.

5.2 RAMP UP ALL OPPORTUNITIES FOR HIV TESTING SERVICES

It is of utmost importance to systematically offer (free-of-charge) HIV testing and counselling to patients in health facilities.

- Focus a particular effort on the systematic testing of patients in TB services, and inpatients in internal medicine and paediatric wards and inpatient feeding centres.
- Replace laborious counselling protocols with simplified but streamlined approaches that focus on individuals who test HIV-positive, directly linking them to care.
- Recognise the role of lay providers and counsellors - in particular PLHIV- and utilise their skills, including in health facilities. Their involvement eases the burden on health staff, while maximising the empathy shown to patients. Formally recognising their contribution, and enlisting their sustained support increases the ability to ramp up testing, link HIV-positive people to care, and help them to adhere to ART.

A complementary strategy is also to **offer testing and counselling services outside health facilities, in well-chosen sites within the community.**

- Involving NGOs, patient associations and community centres in getting people tested is also key. In Kinshasa, for instance, community testing and referral

have been highly effective in identifying HIV-infected people who would otherwise have had no access to diagnosis (as illustrated in the DRC case study).

- Such community responses need to be properly funded at much higher levels than is currently the case, and must be included into the national AIDS plans, if UNAIDS's *Fast-Track* targets are to be met by 2020.¹¹⁸
- Target outreach HIV testing services to key at-risk groups, including sex workers, men who have sex with men, transgender people, people who inject drugs, and prisoners, as well as other context-specific vulnerable groups, including miners, truck drivers and adolescents.

Where deemed relevant and feasible, home-based testing (self-testing) can be used as a complement to health facility or out-of-health facility HIV testing services. This has been piloted in both concentrated and generalised epidemic settings with success, in part because it protects confidentiality.

Substantially increasing the demand for HIV testing is essential, through sustained investment in community-based HIV treatment literacy programmes. Community outreach and innovative communications strategies, such as mobile phone apps and social networks, could also be useful to increase demand.



¹¹⁸ UNAIDS & Stop AIDS Alliance, *Communities Deliver*, September 2015 Available from: <http://www.aidsalliance.org/resources/599-communities-deliver>



5.3 BOOST ACCESS TO ART

WHO's 'Test and Treat' recommendation and UNAIDS's *Fast-Track* initiative considerably simplify decisions on who to enrol for ART, as all people testing positive are eligible, thereby reducing pre-ART loss to follow up, costs and waiting times for enrolment. Countries should adopt **by end of 2016 adequate standard regimens and simplified standard treatment schemes**, as recommended by WHO, and make sure they are implemented as soon as possible. Innovative delivery models will be required to increase the pace of ARV initiation and reach all those who need it.

Accelerate initiation

- In the Kivu's, in eastern DRC, MSF has put HIV-positive people immediately on ART, regardless of their CD4 count, as a way of improving early initiation and retention in care, as a number of patients were lost to care prior to starting treatment.
- In urban MSF projects in the WCA region decentralisation of patients to peripheral health centres is often slow and difficult because of challenges around capacity and quality of care –perceived or real-, as well as patients' fears of poor confidentiality. The pace of ART initiation is mostly faster in ARV centres offering dedicated care and resources, including specific patient support by peers.
- Testing and treatment at community level through mobile clinics could also be a suitable strategy in WCA. MSF has implemented test and treat services in Yambio, a rural conflict-affected area of South Sudan, using simplified counselling approaches

and protocols, including a contingency plan in case the conflict escalates. The programme tested 5,262 patients in 6 months and 178 (82%) of them agreed to start ART the same day; follow up is done through mobile clinics and outside health structures.

Improve quality of care

- Enhance the provision of diagnostics and treatment for common opportunistic infections, by ensuring that this is included in plans and proposals and that adequate funding exists (including by donors). This is a necessary complement to organising access to ART. Patients should not be asked to pay for OI diagnostics and drugs because of insufficient funding from public budgets at national or international levels.
- Integrate HIV and TB services, preferably as a one-stop consultation. This enhances the detection of TB and HIV infection, improves early initiation of TB and ART, and facilitates follow-up and support for HIV/TB co-infected patients, while reducing the time and cost spent by patients and accompanying family members travelling to consultations.
- The use of the WHO recommended fixed-dose combination (FDC) of ARVs, containing tenofovir, efavirenz and lamivudine or emtricitabine, has fewer side effects, benefiting adherence, and reducing a patient's susceptibility to development of resistance if interrupted.¹¹⁹

¹¹⁹ Vitoria M *et al*, Choice of antiretroviral drugs for continued treatment scale-up in a public health approach: what more do we need to know?, *Journal of the International AIDS Society*, 19:20504, February 2016. Available from: <http://www.jiasociety.org/index.php/jias/article/view/20504> | <http://dx.doi.org/10.7448/IAS.19.1.20504>

5.4. KEEP PEOPLE ON TREATMENT AND REACH UNDETECTABLE VIRAL LOAD

Separating ARV delivery from clinical care could be beneficial in a range of settings.¹²⁰ Ideally, one could decentralise follow-up and drug refills for stable patients to the community level, with the patient returning for clinical follow-up (and viral load) once or twice a year. MSF's experience shows that this reduces the burden and the cost for both patients and health services.^{121, 122}

MSF has successfully implemented a number of different community service delivery models, including: appointment spacing for clinical and drug refill visits in Malawi; peer educator-led ARV refill groups in South Africa; community ARV distribution points in DRC; and patient-led community ARV groups in Mozambique.

All four approaches relieved the burden for patients (by reducing travel time and lost income) and health systems (by reducing clinic visits). Retention in care is high: 94% at 36 months in Malawi; 97% at 40 months in South Africa; 89% at 12 months in DRC; and 92% at 48 months in Mozambique. Similar pilots underway in several low-prevalence settings also show promising results.

Depending on the context and the patients' preferences, other approaches in providing refills of ARVs or a combination of these could be devised to improve retention in care, including:

- Provide patients ARV medicines for longer periods of time (3 to 6 months).
- Provide patients with 'buffer stock' of ARV at home. This is of particular interest for mobile populations, people travelling and in places where access to health services can be interrupted by insecurity or violence.¹²³
- Provide community-based ARV refills. MSF has been supporting civil society organisations in different settings with good results. In DRC, for instance, patients using the PLHIV-run community ARV refill sites show higher adherence than patients followed at health facilities (see DRC case study).

- Organize ARV refills at the health facility in a separate fast delivery system, with patients bypassing consultations.
- Allow peer patients or family members to collect medicines.
- Utilise innovative approaches to provide targeted subsidies and remove barriers to access, for example a pre-paid voucher system, whereby healthcare workers are reimbursed for the services provided.
- Implementing a transport voucher system when distance and cost deter people from adhering to treatment, as we see in places such as Mali or CAR.

Roll out viral load testing, including in rural health facilities. Its current availability in WCA is limited outside capital cities or other large urban centres. A combination of approaches is needed, including point-of-care testing, an effective system of collecting or sending samples on dried blood spots (DBS) and – where possible – receiving results by SMS, etc. In case of shortcoming at national levels, sending samples to a regional laboratory could be explored. Viral load machines should be made available through leasing arrangements, in order to assure maintenance and repair. In order to be able to act upon treatment failure, availability and affordability of second-line ARV drugs should also be improved.

Choose ARV regimens best suited to a context of weak health systems and recurrent disruptions of care. Include trials of innovative formulations, such as long lasting injectable ARV and other measures to simplify treatment, making it less burdensome for PLHIV and less dependent on health services.

¹²⁰ Bemelmans M, Baert S, Goemaere E, *et al.* Community-supported models of care for people on HIV treatment in Sub-Saharan Africa, TMIH, May 2014 <http://onlinelibrary.wiley.com/doi/10.1111/tmi.12332/abstract>

¹²¹ MSF, HIV/AIDS: Community models of care explained. Available from: <http://www.msf.org/article/hivaids-community-models-care-explained>

¹²² MSF and UNAIDS, Community-based antiretroviral therapy delivery, Experiences of Médecins Sans Frontières, 2015. Available from: http://www.unaids.org/en/resources/documents/2015/20150420_MSF_UNAIDS_JC2707

¹²³ Providing antiretroviral therapy for mobile populations: Lesson learned from a cross border ARV programme in Musina, South Africa. MSF South Africa. July 2012. Available from: https://www.msfaccess.org/sites/default/files/MSF_assets/HIV_AIDS/Docs/AIDS_report_ARTformobilepops_ENG_2012.pdf



5.5 SCALE UP EFFORTS FOR PLHIV WHO HAVE BEEN LEFT BEHIND

There is still much room to **improve and innovate on the implementation of PMTCT**. Most countries have adopted the more efficient and simplified Option B+ for PMTCT, but its implementation is lagging behind. This needs to be addressed urgently. Further action can be taken to speed scale up, including: offer systematic free and confidential HIV testing in antenatal care settings; promote involvement of lay counsellors in antenatal clinics and maternity wards to reduce the burden on midwives and nurses; include community-based interventions to ensure adherence and avoid loss to follow-up of mother and baby.

Apply and scale up patient-centred models of care to tackle paediatric HIV/AIDS. These include:

- Integrating early infant diagnosis, using DBS sampling of heel prick blood for babies of all PMTCT mothers when attending postnatal follow-up and under-five clinic services. This can be combined with sending results by SMS or other technology.
- Using existing point-of-care testing platforms such as the GeneXpert is also an option.
- Timely access to ARVs in the optimal paediatric formulation for babies.
- Testing children who are at higher risk (e.g. children who are malnourished¹²⁴, infected with TB, family members of known HIV patients, etc).
- Task shifting for paediatric ART from doctors to nurses and clinical officers.

- Providing support for adherence and gradual disclosure to children and their parents or guardians in a child-friendly environment.
- Providing community-based and peer support.

MSF has shown that it is possible to achieve improved coverage for children in low-prevalence settings. In Niger, for instance, MSF has started testing severely malnourished children for HIV in the Inpatient Therapeutic Feeding Centers (ITFC) of Madaoua and Bouza Hospitals. Between June 2014 and December 2015, 1.03% and 1.69% of those tested in each site respectively were found to be HIV-positive (compared to a national HIV prevalence of about 0.8%). Paediatric ART was implemented in the rural clinics thanks to task shifting. MSF has carried out similar interventions in Chad, Mali and CAR.

Focus special attention on adolescents living with HIV.

Not only are they key in reducing HIV transmission, there are few services available that are adapted to their specific needs. MSF puts an emphasis on providing psychosocial support to young people with HIV to help overcome stigma and isolation and foster hope for the future. Adolescents who acquired HIV around the time of birth may learn quite young about their disease quite young, or they may learn much later, which can often be harder. HIV-positive teenagers may worry that if they disclose their status, dating may no longer be an option and they will lose friends. Others may not be properly informed about the disease as a result of their parents' fear of stigma and discrimination. The adolescent support groups in MSF's project in Epworth, Zimbabwe are an example of a safe haven for HIV-positive teens to interact and share their experiences.¹²⁵

Focus attention on other groups of higher-risk people, who are often marginalised and in many cases face criminalisation (13 countries in WCA criminalise same-sex sexual relationships, and 14 countries criminalise sex work¹²⁶).

Testing campaigns which target higher-risk groups, adequate funding for targeted interventions and efforts to tackle discrimination, stigma and legal barriers are all essential. Adjusted models of care that reach out to these specific at-risk groups are also essential, as used by MSF in programmes in Myanmar and also in Kimbi, DRC, where we run an STI clinic for miners and sex workers. The clinic has working hours and services that are adjusted to its target population groups for better acceptance.



¹²⁴ Madec Y, Germanaud D, Moya-Alvarez V, et al. HIV Prevalence and Impact on Renutrition in Children Hospitalised for Severe Malnutrition in Niger: An Argument for More Systematic Screening. Plos Medicine 2011, vol 6.

¹²⁵ MSF, International Women's Day: Medical and psychosocial support for teenagers with HIV, March 2015. Available from: <http://www.msf.org/article/international-womens-day-medical-and-psychosocial-support-teenagers-hiv>

¹²⁶ UNAIDS, 2016-2021 Strategy. On the Fast-Track to End AIDS. *Op.Cit.*

5.6 RESPOND TO NEEDS OF PLHIV IN CRISIS SITUATIONS

The debilitating effect of conflict and crisis situations on weak health systems and low ART coverage can be countered by preparedness and contingency planning. Providing patients with several months' worth of ARV refills can help keep them on treatment even during the emergency phases of a crisis. Implementing the IASC 2010 guidelines is essential, even during the emergency phase. All stakeholders (both NGOs and UN agencies) should actively support this, and advocate for including HIV in the cluster coordination mechanism.

For several years now, MSF has been using contingency plans to respond to crises. Here are some examples:

- In Yemen in 2011 and 2015, patients were provided with 4 months' supply of ARVs; an additional ARV delivery point was created in the capital from where supplies were transported to people in affected rural areas; a "hot-line" was implemented for patients to call before they ran out of drugs and to arrange a safe place for the drugs delivery; the HIV associations' leaders were involved in the follow-up of patients.
- In both Yemen and CAR, patients on ARVs received "run-away packs" containing an extra supply of drugs to take with them if forced to flee. However, the outcomes were very different. After the 2011 crisis in Yemen, 97% of all patients returned for consultations, while in CAR, only about half returned when security situation improved in March 2014, with the other half lost to follow-up, possibly after having fled the country. These differences may be attributable to different geographic settings, education level and types of violence. The divergent effect in urban and rural areas also shows the need for situation-specific adaptation of the response.¹²⁷ The national AIDS programme in Yemen has since adopted MSF's contingency plan and is currently implementing it nationwide.



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¹²⁷ Ferreyra C., Palacios L., Revuelta A. *et al.*, Ensuring continuation of antiretroviral therapy during acute instability: the experience of MSF in Central African Republic and Yemen, May 2014, available from: http://www.msf.org.uk/sites/uk/files/5_ferreyra_car_yemen_final.pdf

Dr Abdulfattah Al-Alim, Field coordinator and medical team leader of the MSF HIV/AIDS project in Yemen, explains how antiretroviral treatment was ensured "underneath the bombs" in Yemen when the conflict broke out in March 2015:

First, we called the patients who we knew were in the most unstable governorates, such as Sa'ada, Al-Dhale, Hajjah and Aden; then those living in the most difficult areas of the capital; and thirdly, people who had appointments at the clinic to pick up their medication in the coming months. By the beginning of April, we had managed to contact 745 of the 773 who were in treatment at that time in Sana'a. With the help of the HIV/AIDS associations and the International Organization for Migration, we were able to find many of those who did not respond.

Then we started to give a two-month supply of ARV drugs to all patients. Many were able to come to the clinic to collect them, but for many others this was impossible, because of the fighting or a lack of fuel or money to travel. So we sought the best way to meet them and give them their treatment. Abdulbaset, the nurse in charge of the pharmacy, and I delivered the drugs in several places, sometimes even risking our physical integrity; for instance, at locations that are next to military facilities and are usually targeted by air strikes. Also, Abdulbaset and members of the HIV/AIDS association delivered drugs to rural villages outside Sana'a by motorcycle. Furthermore, the people receiving treatment had our phone number so they could call us directly and clear up any doubts. Although even talking on the phone sometimes wasn't easy, due to electricity cuts and attacks on the telecommunication systems.

As the war continued and access to some of the clinics became more difficult, we took a step forward by giving patients enough ARV drugs for the rest of the year. To support people living with HIV at this particular time, we have also created a programme called 'Be-Insured', whereby leaders of the HIV associations call patients to check their health, drug stock and psychological and financial status. Then, our team provides psychological support for those in need.

The current heightened donor interest in so-called 'fragile states' focuses on prevention or mitigation of recurrent violence or crises. The high frequency of repeated cycles of disruption in these contexts presents a clear argument for systematic preparation to manage treatment for HIV patients, including detailed scenarios, clear contingency plans and stocks. As a case in point, delivery models that foster increased patient autonomy by a simplified and flexible approach have a greater chance of resisting disruption during crises.

In strategic terms, it is clear that a simple system – including task-shifting, community engagement, long refills and buffer stocks – is particularly suitable for crisis-prone contexts. At the same time, experiences that work well during crisis situations may equally benefit patients and programmes confronted with fragile or failing health systems outside times of emergency.

ANTICIPATE AND PREPARE FOR EMERGENCY SCENARIOS

Every ART programme should have a contingency plan for emergency scenarios. Practically speaking, the minimum plan includes: a contingency stock of ARVs and other essential medical supplies; an emergency notification mechanism for problems and responses through adapted supply channels; and a method of swiftly communicating with patients and health workers (e.g. a central point of information and toll-free phone number). The necessary staff and resources need to be planned, trained and allocated to establish these mechanisms ahead of a possible crisis. The rapid mobilisation of financial resources is particularly important. Patients should also have updated health passports and an ART buffer stock.

Additionally, in the contexts of weak health systems, a systematic push towards patient autonomy and simplification of procedures will increase the system's resilience and robustness, both during emergency situations and in normal circumstances, with clear benefits of improved reactivity to patients' changing needs and an evolving context.

After such crisis situations, a catch-up plan is needed, in which patients lost to follow-up are traced proactively, while efforts are made to compensate for those activities put on hold during the crisis. Accelerated testing and initiation can, at least in part, mitigate the shortfall. Additional human and financial resources need to be allocated to speed up service provision and reach out to patients in this post-crisis phase.



6. AN URGENT CALL FOR A CATCH-UP ACTION PLAN TO CLOSE THE TREATMENT GAP IN THE WCA REGION

A major fast-track plan to close the HIV treatment gap in the WCA region and other contexts with low coverage is long overdue. Failing to increase treatment will jeopardise achieving the worldwide target of 90-90-90 by 2020. Already, the WCA region contributes 21% of all new infections worldwide and over a quarter of all AIDS-related deaths.

The proposed priority framework in UNAIDS' fast-track strategy focuses narrowly on populations which contribute the most to the expansion of the epidemic. The effect of this narrow focus will be to ration lifesaving interventions at the expense of populations perceived to be of marginal interest for epidemic control, such as people in areas with lower HIV prevalence, or in countries with smaller populations.

These people cannot continue to be left behind and die out of focus. The current major shortfalls and backlog in HIV treatment in WCA can be overcome. The 2015 WHO 'treatment for all' guideline provides an important opportunity to revise current practices and adopt evidence-based strategies for accelerated implementation.

But to support and implement strategies that have shown to be effective in rolling out key interventions and to develop new approaches, a sense of urgency is required, and a number of obstacles in policy and politics must be tackled.

MSF proposes the launch of a catch-up plan, clarifying and highlighting priorities for implementing strategies that work, and tackling major obstacles in policy and practices, with clear measurable outputs in the short term.

- All people wherever they live have a right to lifesaving treatment. Therefore global ambitions should include that **at least 90% of all countries should reach 90-90-90**. The WCA region cannot be forgotten in the global call to fast-track the HIV response. Worldwide priority should go to where the treatment gaps are widest. For countries where ART coverage is below 30%, existing initiation rates need to be tripled by 2020.
- **Political leadership** is key to getting HIV high on the agenda in low-coverage countries in order to mobilise donors and development partners. Relatively low prevalence should not mean low priority -not for governments and not for donors. Leaders need to understand that the present moment is the best opportunity to curtail the epidemic; failing now, they face the risk of falling into a 'treat forever' scenario.
- Countries in WCA should establish and adhere to **clear and ambitious national targets** that encourage earlier access to services, and also implement those approaches that have proven successful. Progress towards these targets should be regularly reviewed and adapted. UNAIDS should promote **specific annual 'challenge' targets** in these low-coverage countries in order to double the rate of treatment initiation over the next three years and triple the rate by 2020.
- At country-level, a **strategic implementation plan for changes in the short term** should be adopted. In support of this, priority funding allocation, programmatic training, and a technical and organisational support plan should be developed. This includes technical assistance from WHO, UNAIDS and others to implement the 2015 WHO guidelines as soon as possible, ideally during the course of 2016. Major efforts are needed to break the relative isolation of countries in the WCA region and organise active dissemination of innovative and successful experiences, in the main languages of the region.

- **Five axes** should be prioritised to assure the implementation of a **'Treat All' approach**:

- A strict 'No pay' policy. In WCA there is a need to re-affirm and pro-actively assure that health services are provided free-of-charge to PLHIV. Access and quality of care for PLHIV need extra protection in weak and inequitable health systems.
- Alternative ART delivery mechanisms that bring treatment closer to PLHIV, in less burdensome ways. In response to the weakness and inequity of existing health services, important efforts have been made, but these efforts often do not translate into rapid and practical changes at health facility level, such as easier ART refills. ART treatment at community level and increased patient autonomy are critical. Implement 'Test and Treat' approaches and organise accelerated inclusion by dedicated ART initiation services.
- Immediate action for severely ill patients. Focus attention and resources on severely ill patients – some already within health facilities – who are waiting for lifesaving treatment. They need to be offered HIV testing, be put on ARVs immediately and receive necessary care, including for opportunistic infections, without becoming completely impoverished.
- Support for empowered patient associations and civil society. Associations of PLHIV and civil society are key components in the roll-out of HIV services. It is crucial to rectify side-lining and reduced funding for civil society if we are serious about a significant scale-up. We urgently need lay providers to support testing, linkage to care, adherence support and provision of community-based HIV-services. Patient associations are vital to carrying out independent monitoring at health facility level and to raising the alert when the necessary care is unavailable or inaccessible. They also have a crucial role in mitigating stigma and discrimination.
- Adapt to fragile health systems and prepare for disrupted services. The question is not if problems will arise, but rather when they will. In order to respond quickly to disrupted services, contingency and back-up plans should be part and parcel of the system.

In fragile systems, flexibility and nimbleness are important to respond rapidly to emerging problems and volatile contexts. The weakest link in a chain can paralyse an entire country's HIV programme. Multiple, interchangeable and complementary channels for supplies and financing are recommended. Communities have shown a remarkable ability to adapt to changing situations and to mobilise to find short-term solutions.

Displacement, conflict, drought and outbreaks will likely (continue to) affect the region over the coming years. A clear commitment by all governments, UN agencies and donors to include ARV provision in the early stages of crises is needed. While continued ART must be assured, we also cannot afford to drop the pace of initiation, as this will widen the treatment gap. This situation demands the implementation of clear preparedness plans, both at regional and country level.

- **To implement this action plan, adequate funding should be mobilised towards these priority strategies.**

- Available resources should be prioritised for proven strategies and interventions. This might necessitate re-allocation of existing budgets through facilitated reprogramming and channels that allow swift disbursement and use of the funds.
- Alongside the Global Fund, bilateral donors that support health in these low-coverage countries should include additional support to ARV and HIV care in order to help close the existing gap.
- Where the Global Fund is the main donor present, and often the only provider of ARVs, the fragility of such a monopoly in terms of funding commitments, management and disbursement should be mitigated by flexible and complementary funding channels.
- While it is essential that governments of countries affected increase the allocation of domestic resources for health in general, and for HIV in particular, this will not suffice. International partners must maintain financial (and technical) assistance for scaling up ART and prevention, especially as the world moves to roll out the 'treatment for all' approach.

- **Innovation to overcome stagnation.** New ways of thinking about ART are needed in these countries with low coverage. In order to achieve fast-tracking the HIV response in WCA and reach 90-90-90 by 2020, certain approaches will have to be abandoned; more out-of-the-box ideas should be embraced. A conversation on the specifics of the region should be launched at international level to identify what innovation can bring the necessary changes. Pragmatic operational research can yield useful short term results. A revised research agenda should put the needs of PLHIV in the WCA region at its centre.

7. CONCLUSION

The people left behind by the HIV revolution over the past decade, including those in the WCA region, should not be forgotten once again. For these populations, the few next years -until the 2020 deadline set by UNAIDS to reach the 90-90-90 targets and curb the epidemic- will be crucial in reducing death, suffering and transmission of the virus. This may be their last chance to benefit from what the world has learned from the successful mobilisation against HIV.

While countries in WCA have relatively small numbers of PLHIV when compared with the Southern Africa region, the health burden from HIV/AIDS in these countries is significant, primarily for patients but also in some places for health services. Conflict and epidemics of other diseases are partly responsible for the ART coverage backlog, but underlying factors such as the lack of national and international political will and interest, weak and inequitable health services, and lack of support for patient associations and civil society, exacerbate this situation.

Both governments and the international community place relatively little political importance on ART in these countries; HIV is low on their priority list and receives scant attention. As a result, the need to adapt policies and adopt effective strategies is underestimated or even denied.

Attempting to integrate HIV services into weak general healthcare facilities, without pre-conditions to ensure that care is available and accessible, is failing PLHIV and hindering the urgent need to scale-up ART. If patients are to overcome the existing obstacles to access and to adhere to treatment, additional dedicated support is needed. ART delivery strategies, including innovative and effective models of care, need to be reviewed and adapted to these contexts.

We recommend actively developing and implementing a *fast-track* catch-up plan and transferring knowledge and experience on effective ART delivery, including mobilisation of civil society, from other contexts. Otherwise the gap will only widen between those countries that have achieved good treatment coverage and those which are lagging behind.

The current international context of HIV, in which support and ARVs are rationed to limited areas, is not favourable to the WCA region. Without targeted mobilisation to help countries of the area fight HIV and make lifesaving treatment accessible to those who need it, there is a major risk that PLHIV in these countries will remain out of focus and be left out. Global goals to curb the HIV epidemic by 2020 cannot be met unless the HIV response is fast-tracked to benefit people and communities in countries with lower prevalence and low ART coverage, especially in West and Central Africa. To deny PLHIV in WCA effective access to lifesaving treatment would be not only a human and medical failure, but also a strategic mistake in the fight to bring the HIV epidemic under control.

8. CASE STUDIES



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Central African Republic
Democratic Republic of Congo
Guinea



Epidemiology

Number of people living with HIV	140,000	[120,000 - 150,000]
Pregnant women living with HIV	5,400	[4,900 - 6,000]
Children aged 0 to 14 living with HIV	15,000	[14,000 - 16,000]
Deaths due to AIDS	9,900	[8,100 - 14,000]
New infections annually	8,200	[7,000 - 9,800]
Adults aged 15 to 49 prevalence rate	4.3%	[3.9% - 4.6%]
HIV prevalence in key populations:		
-Sex workers	9.2%	
-Prisoners	N/A	
-MSM*	29%	

Source: UNAIDS 2014 data, available from <http://aidsinfo.unaids.org/>

Source *: National Strategic Plan for HIV 2015.

Note: Data and information collection methods vary widely according to the source. Caution in their interpretation should therefore be exercised.

CENTRAL AFRICAN REPUBLIC (CAR)

HIGH HIV PREVALENCE FUELLED FURTHER BY RECURRENT CRISES

OVERVIEW

The Central African Republic (CAR) has seen decades of recurrent crisis and instability, but with the onset of a new cycle of violence since December 2012, the country is facing the worst humanitarian crisis since its independence. Recent estimates indicate that more than 435,000 people are internally displaced (IDPs), over 465,000 have taken up refuge in neighbouring countries (Figure 1) and 2.7 million people (more than half of the population) are in urgent need of humanitarian assistance.¹

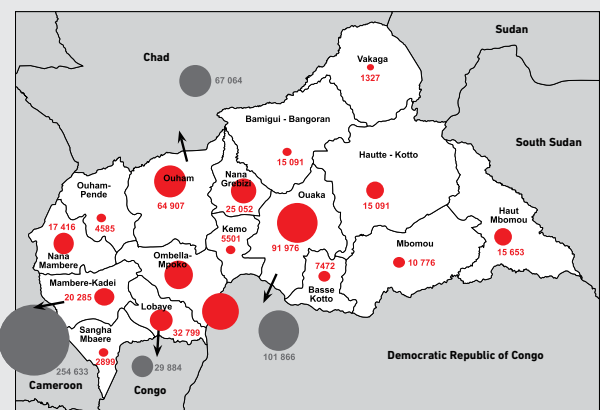
Poverty is widespread in the country. While already 66% of the population lived on the equivalent of less than US\$1.9 per day in 2008 the recent conflict has further impoverished people.² A study showed that households affected by HIV were significantly more affected by poverty.³

The HIV program is embedded in very weak health systems, sometimes described as non-existent even prior to the latest civil conflict.^{4,5} CAR has among the worst health indicators in the world: the sixth-highest child mortality, the third-highest maternal mortality rate, a life expectancy at birth of 51 years, and a probability of over 40% to die before the age of 15 (all causes together).⁶

HIV/AIDS has been the leading cause of death among the general population since 2000 (malaria being the main killer for children under five years of age).⁷ A mortality survey carried out by Epicentre/MSF in the city of Carnot in 2012 highlighted that one in three deaths among people aged 15 and above was attributed to HIV/AIDS by the people interviewed.⁸

The last few years of violence have decimated already fragile health systems. Health facilities have been looted and medical staff have fled their posts. Lack of essential medicines, supplies and health professionals have seriously hampered the provision of primary and secondary health care. A 2014 study on 815 health structures in the country showed that only 55% were still functional.⁹ In many places where MSF is present, the only existing health staff have only a minimal three month training; these so-called "secouristes" gain most of their experience on the job. There is a lack of qualified medical staff in the rural areas. Health staff based in the capital are difficult to relocate due to the ongoing insecurity.

Figure 1:
Displaced populations within and around CAR.



● Refugees (as of Dec 3rd 2015)

● Internally displaced persons (as of November 10th 2015)

➔ Population movements

Source: UNHCR, December 2015.

¹ UN data mentioned by the Global Centre for the Responsibility to Protect: http://www.globalr2p.org/regions/central_african_republic

² World Bank Data. Available from: <http://data.worldbank.org/country/central-african-republic>

³ PNUD. Impacts du VIH/SIDA sur le développement en République Centrafricaine. Document de synthèse. 2005.

⁴ Mark Beesley, Health Service Provision in the Central African Republic, 2012. Available from: http://globalhealth.ku.dk/events/2013/health-as-a-human-right/programme/Mark_Beesley_20022013.pdf

⁵ MSF, "Central African Republic: a State of Silent Crisis", November 2011. Available from: <http://www.doctorswithoutborders.org/sites/usa/files/A%20State%20of%20Silent%20Crisis%20EN.pdf>

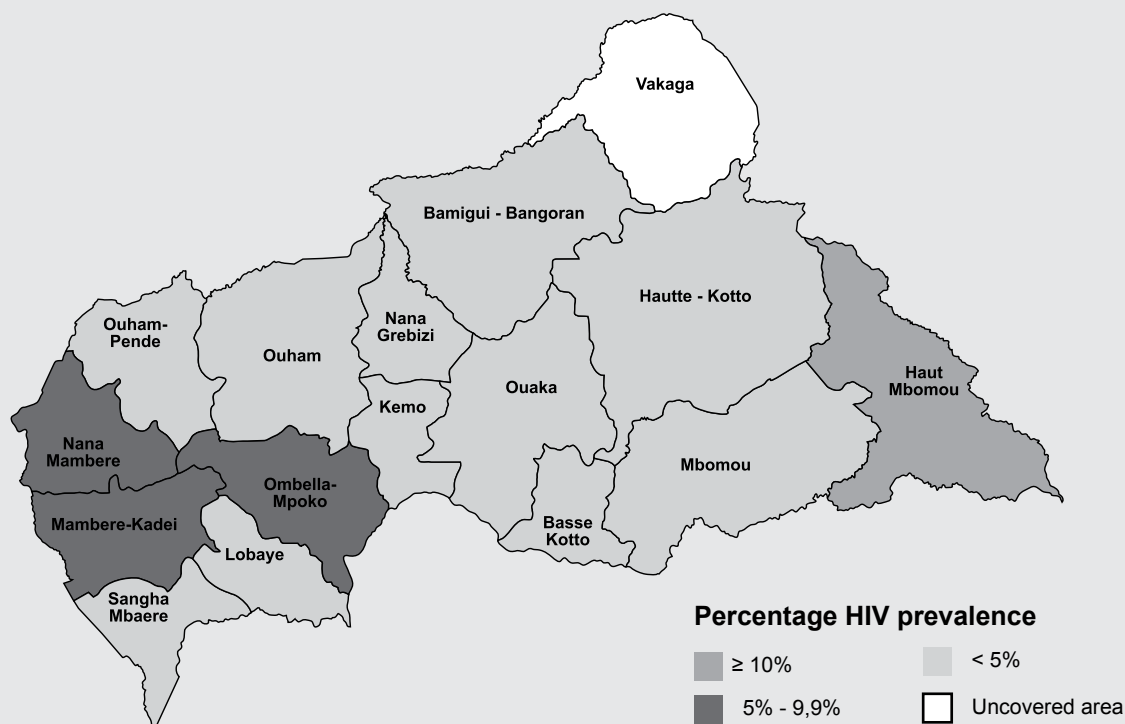
⁶ WHO : Statistical profile of the Central African Republic, available from <http://www.who.int/countries/caf/en/>

⁷ Ibid.

⁸ Epicentre, Enquête de mortalité rétrospective dans la ville de Carnot, Préfecture de Mambéré-Kadéï, République Centrafricaine, Janvier - Juillet 2012.

⁹ OCHA data cited by ACAPS, Central African Republic, Country Profile, July 2015. Available from: http://www.acaps.org/img/documents/c-acaps_country_profile_car_27_july_2015.pdf

Figure 2:
HIV prevalence rates (15-49 years) in different parts of CAR, 2010. Source: MICS 2010



Despite an increased presence of NGOs and UN missions since the 2012 crisis, health care services function largely on out-of-pocket payments. This is particularly problematic in a country where 60% of the population lives under the poverty line. A government decree exempting patients from payment during the crisis was implemented in August 2014, for a period of one year. However, this free care policy is limited to certain patient groups (primarily women and children) and to NGO-supported health facilities as part of the Humanitarian Cluster's strategic plan. Further expansion is hampered by insufficient funds to replace revenues from patient fees and challenges to respond to increased demand for care when fees are no longer a deterrent. The decree on free health care was extended to March 2016 and is pending further prolongation.

UNAIDS estimates the national HIV prevalence in CAR at 4.3%¹⁰ - the highest in the central African region. There are notable inter-country variations (3-12%) - the highest rates being in the eastern and western border areas -and differences also exist between urban (8%) and rural (3%) areas.¹¹ HIV prevalence is estimated to be higher among key population groups: sex workers (9%), men who have sex with men (29%), and mobile population groups such as fishermen, miners, truck drivers and people in uniform.¹²

¹⁰ UNAIDS 2014 data, available from : <http://aidsinfo.unaids.org/>

¹¹ ICASEES, 2010. Enquête par grappes à indicateurs multiples (MICS), RCA 2010, Rapport final. Bangui, RCA.

¹² UNAIDS 2014 data, *Op.Cit.*





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PROGRESS TOWARDS THE 90-90-90 TARGETS

Ensuring a good coverage of early ART and providing lifelong care for HIV prove particularly challenging in CAR. Table below shows the main indicators for estimated coverage of essential elements of HIV care.

Continued civil unrest has had a deteriorating effect on the HIV situation, with treatment disruptions, loss to follow-up and a high incidence of gender-based violence. Health facilities have been looted or destroyed, and health staff and populations have fled. The recently increased presence of international NGOs and UN-agencies resulted in an enhanced although still limited coverage of HIV services. CAR has one of the lowest ART coverage rates in the world, currently at 18%.

Against this background of low coverage, the national authorities have developed a range of plans aimed at boosting the HIV response, including a national strategic framework (US\$250 million for the period 2015-2020), capacity building in the country, identification of treatment sites and guidelines for HIV monitoring and evaluation of the program to name a few. A contingency plan is also being put in place at national level to better respond to HIV needs and continuation of care during periods of instability.

Coverage estimates for essential elements of HIV care

Estimated coverage rates:	%
% tested	N/A
% pregnant women enrolled in PMTCT	47
% PLHIV on ART	18
% HIV+ children on ART	11
% patients co-infected TB-HIV on ART	37*
% patients on ART retained in care after 12 m	63**

Source: UNAIDS 2014 data, available from <http://aidsinfo.unaids.org/>

Source*: 2014-2018 National TB Programme Strategic Plan

Source **: Global Fund data-WHO cohort analysis June 2015.

Target 1: By 2020 90% of PLHIV will know their status

No recent reliable national data on the number of people tested for HIV exists. Survey data collected in 2010 suggested an HIV testing coverage of 36% (versus 19% in 2006).¹³

Outreach HIV testing and counselling (HTC) was largely reduced to fixed sites and diminished since 2010. As of 2013, only half of the 23 Voluntary Counselling and Testing (VCT) sites were functional.¹⁴ Furthermore, these are mainly concentrated in the capital, Bangui. HIV testing is not always free of charge¹⁵ and the uptake of voluntary testing is low. Testing at facility level is not systematically done (even for patients with TB), due to lack of awareness, poor training and motivation of health staff, cost of tests to patients and frequent stockouts of tests.

In MSF and other NGO-supported facilities, where tests are offered free of charge, the uptake of HIV testing is high and shows HIV positivity rates exceeding the HIV prevalence rate among the general population; as such, large numbers of HIV positive individuals have been diagnosed.

For example

Carnot: Since 2010, i.e. prior to the civil conflict, MSF has provided HIV care (including HIV testing) in collaboration with the health authorities. HIV positivity rates at the start of the program were alarmingly high: 22-26% among in-patients, 9-12% among women during first antenatal visits; 8-12% among in- and out-patients.

Boguilá: In primary and secondary health care programs run by MSF, 50% of patients admitted to the adult internal medicine ward were HIV positive.

Berberati: An MSF baseline exploratory survey in 2015 found HIV positivity rates of 50% among TB patients, 29% among hospitalized patients, 20% among hospitalized children and 14% among women attending ANC.

Bangassou: Similarly, in the MSF programme of Bangassou, 33% of TB patients are HIV co-infected, and 25% of patients hospitalized in medical ward have tested positive, as have 8% of blood donors.

Ndele, Kabo and Batangafo: In these northern parts of the country, MSF teams report HIV positivity rates of 33% at the VCT level and around 3% in ANC.

Zemio: 11% of pregnant women tested in antenatal care are found HIV positive.



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¹³ ICASEES, 2010. Enquête par grappes à indicateurs multiples (MICS), RCA 2010, Rapport final. Bangui, RCA.

¹⁴ ONUSIDA. Impacts de la crise humanitaires sur l'offre des services de prévention du VIH, des soins et de traitement ARV en RCA. Une analyse du bureau pays, Avril 2014.

¹⁵ For instance, in Berberati public health facilities, an HIV test is charged 1,000CFA or the equivalent of US\$1.69.

Although these results paint a rather bleak picture, they point to the largely untapped potential of hospitals and other health facilities to identify PLHIV.

Testing among pregnant women: The country started PMTCT services in 2001 and introduced ARV treatment around 2006. From a total of 119 planned PTMTC-sites, 61 are reported as functioning, with 21 in Bangui.¹⁶ Data from GF-supported health facilities indicate that in the latter half of 2014 only 11% of pregnant women were tested for HIV during ANC. Given that most recent data estimate ANC coverage to be around 34%¹⁷, overall coverage of HIV testing among pregnant women is undoubtedly lower.

One of the barriers to HIV testing during ANC is cost: some facilities require women to pay for the first antenatal visit (the equivalent of US\$1.8 for a patient card and basic laboratory tests) and only should they test positive for HIV is subsequent ANC free of charge. In Paoua for example, HIV detection in ANC dropped significantly when MSF handed over maternal health services to the Ministry of Health, and staff began applying a first visit fee policy.

Early Infant Diagnosis (EID): Very few HIV-exposed infants receive a PCR test –which is only available in Bangui. Between May and July 2015, only 467 PCR tests were done (7% positivity rate). One test costs the equivalent of US\$57 and UNICEF currently covers the cost of these tests but at a cap of 500 tests per year.

EID can be performed on Dried Blood Spot (DBS) samples sent to the central laboratory in Bangui. However, logistical issues mean that DBS paper is only available in large quantities in the capital and that supplies do not reach prefectural labs. Timely communication of results is a problem –even for DBS samples within Bangui. In Carnot, between January and August 2015, 56 HIV-exposed babies were tested with DBS, but results were never conveyed back from the capital. This has led to some MSF programmes having to send their DBS samples to a laboratory in Durban, South Africa.

To counter poor access to EID, MSF is introducing in some places alternative diagnostic methods (including point of care for viral load, EID through samples on DBS or Xpert QUAD).

Through systematic HIV testing in nutrition recuperation centres, MSF was able to identify HIV positive children (and their mothers) and offer them paediatric HIV treatment. In Carnot for instance, MSF started systematic HIV screening in the nutrition ward in June 2015.

Target 2: By 2020, 90% of PLHIV will access ART

At the end of 2014, 24,142 persons were reported to be on ART, with national coverage estimated to be at a mere 18%.¹⁸ There are large variations across the country however, with coverage rates as high as 60% reported in the capital. Regions where international NGOs are present have seen small improvements in ART coverage, but there are still considerable unmet needs.

A multitude of factors hamper ART access and uptake: Persons who test positive for HIV are often not linked to treatment and care; they cannot afford service fees; HIV services are unavailable near where they live. Distance from facilities, difficult and insecure road travel, limited transport means and transport costs all impede access to treatment facilities. For instance in Zemio, close to the border with Sudan, patients travel as far as 160km and 200km from Mboki and Obo areas to receive care.

Another factor is insecurity. According to UNHCR estimates, the continued unrest has led to about 1,000 patients on ART being displaced as of the end of 2015. Over 2% of displaced people in Bangui were estimated to be on ART.¹⁹ In the MSF program in Boguila for instance, due to ongoing insecurity, ART scale up has been drastically reduced, focusing only on those who were already on treatment.

Patients access treatment quite late, when already seriously ill. This leads to very high HIV rates among hospitalised patients and HIV is an important contributor to mortality among in-patients. In hospitals supported by MSF, 25 to 29% of in-patients have an HIV-related illness and 84% of intra-hospital deaths are linked to HIV.

Some of the main factors hindering progress are as follows:

- Lack of decentralization of ART delivery at peripheral level (only done by a few NGOs).
- Extremely slow progress in task-shifting ART initiation to nurses; reliance on doctors who are in short supply and concentrated in the capital impedes scale-up.
- Patients required to come once a month to health facilities for drug refills (except where supported by NGOs). Transport costs and waiting times at clinics are a deterrent and hamper retention in care.
- Poor integration of TB and HIV services. According to national TB program data, 37% of TB patients are HIV positive (in MSF projects in Paoua and Carnot this figure is around 50%) and yet only 9-12% of TB-HIV co-infected patients are on ART.²⁰ Systematic HIV testing of TB patients is not done in MoH structures due to lack of awareness and lack of tests.

¹⁶ CNLS. Plan stratégique national de lutte contre le VIH et le SIDA 2016 – 2020. Bangui, December 2015.

¹⁷ *Ibid.*

¹⁸ UNAIDS 2014 data, available from <http://aidsinfo.unaids.org/>

¹⁹ Henghuber H., HIV/SIDA dans la situation humanitaire en RCA. Présentation pour le cluster CCM. Points focal HIV/TB pour UNHCR et Fonds Mondial. 2014.

²⁰ 2014-2018 Strategic Plan of the national tuberculosis (TB) programme.

- Slow roll out of the WHO 2013 guidelines which were officially adopted in 2014. Only now are patients being enrolled under the tenofovir (TDF) regimen²¹, and the CD4 count < 500 cut-off was only adopted in September 2015.
- Cost of care. ARVs and drugs for opportunistic infections (OI) drugs should be free-of-charge according to national regulations.²² In practice however, out-of-pocket payments (for consultations, patient cards, laboratory tests, etc.) are often required before patients can access ARVs. No free treatment access exists for severe OIs such as Cryptococcus or Kaposi Sarcoma, among others.
- The Global Fund (GF) covers the cost of CD4 testing, but much of the testing equipment in the country is non-functional. Conversely, in absence of donor funding of viral load (VL) testing, the high cost has to be covered by the patient. VL testing facilities also only exist in the capital, rendering them inaccessible to most rural and remote populations.

While ensuring ART continuation is recognised by most as being at the core of the HIV response during crisis situations, this focus has at times led to a de facto embargo on new ART initiations. This is difficult to accept, as it leads to patients being excluded from essential care, a practice which comes at a heavy price. It is also contrary to WHO's recommendation to 'treat all' and leads to many missed opportunities to save lives and curb the epidemic. Patients already on ART often have difficulties to show they were on treatment previously, as they might have lost documentation during displacement and/or when seeking care in other health facilities. Moreover, in the context of patient fees being charged for laboratory tests, important financial barriers exist to (re)start ART. In Bangui, severely ill patients from displaced camps, who were referred to medical doctors certified to prescribe ART, were refused treatment because they could not prove previous enrolment; doctors were following instructions to prescribe treatment only for ongoing care. The lack of clarity on ARV availability in the country further restrained ARV initiations in peripheral health facilities. Also, current guidance by UNHCR limits ARV provision to continuation of existing treatment only.

Children: Alarming, nine in 10 children in need of ART are not receiving it.²³ This is underpinned by lack of trained staff, non-availability of paediatric ARV formulations and as aforementioned, lack of diagnosis of HIV infected children.

PMTCT: The 2014 UNAIDS estimate of a 47 % PMTCT coverage among the 5,400 HIV positive pregnant women²⁴ would seem to be an overestimate in view of low ANC coverage and of very low levels of HIV testing among pregnant women in those antenatal services (11% in 2014). In addition, only about a third of the 119 PMTCT sites existing in 2014 are still functional.

GF monitoring data further indicate that between May and July 2015, 1,299 women started on ART.²⁵ The World Bank is also supporting PMTCT care in its health system strengthening program, providing PMTCT to 2,528 patients by July 2015.²⁶ Task shifting of PMTCT to nurses and midwives has been implemented and even traditional birth attendants working at health facility level are being trained in PMTCT.

Although Option B+ was officially adopted in 2014, outside of the capital it is currently only available as part of maternal health care in a few sites. At the national level, half of the women enrolled in PMTCT are on option B+, while the other half are on option A. However, not all PMTCT sites provide lifelong ARV and some women in PMTCT, for instance those in Berberati, need to seek ARV care elsewhere after delivery.



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²¹ 1st line ARV chosen in CAR is TDF+FTC+EFV (Directives Nationales TARV – 2014)

²² Loi relative au VIH/SIDA en République Centrafricaine. Article 42.

²³ UNAIDS 2014 data available from: <http://aidsinfo.unaids.org/#>

²⁴ *Ibid*

²⁵ Based on Global Fund monitoring data

²⁶ World Bank Health System Support project in CAR, August 2015. Available from: http://www-wds.worldbank.org/external/default/WDSPContentServer/WDSP/AFR/2015/09/02/090224b0830b234a/1_0/Rendered/PDF/Central0Africa0Report000Sequence007.pdf

TARGET 3: BY 2020 90% OF PLHIV ON ART WILL HAVE AN UNDETECTABLE VIRAL LOAD

Systematic viral load (VL) testing is not yet available in CAR. In Bangui, two machines operate: one by the Institut Pasteur and another at the National Laboratory by the NGO ESTHER (now FEI). VL testing was not included in the Global Fund grant. Lack of funding for operational costs means that free access to testing for patients is severely rationed (200 free tests per year by Institut Pasteur and 700 by ESTHER). Beyond these quotas, patients are required to pay the equivalent of US\$60-67 per VL test, which is unaffordable for most.

Where VL testing is available, restrictive selection criteria are in place. In Bangui's ambulatory treatment centre for instance, only patients who have been on ART for over two years and have shown no rise in CD4 count can have VL testing. VL data at present are therefore of limited programmatic use.



Recent estimates indicate that retention in care at 12 months is only 63%.²⁷ This likely reflects the burden to patients of the current model of care. First, despite the revised ART guidelines recommending decentralized care ("sous-site ARV"), this has not yet been implemented in the public health system. Second, monthly ARV drug refills and monthly consultations are still required of patients even if they are stable and not in need of clinical care. Third, despite the guidelines including task shifting to nurses for ARV drug prescriptions and to all staff for ARV drug dispensing, this is still far from being the reality. Fourth, policy guidance for adherence support during pregnancy and breastfeeding and follow-up of mother-baby pairs lacks clarity.

Finally, service delivery is poorly adapted to the current context of recurring episodes of violence and crisis. This includes the absence of buffer stocks at health facilities and at the patient level to allow ART continuation if health facilities are out of reach.

Contingency plans

To ensure continuation of ART during the peak of violence in 2013, MSF implemented contingency plans as a pilot in Kabo, Batangafo and Ndele. When insecurity increased, almost 90% of patients on ART received an extra 3-month supply of ARVs. Despite high uptake by patients, only about half of these patients returned to the MSF-supported facilities once security levels improved. Although we can only speculate, we suspect that many of the patients that did not return died or crossed the borders into neighbouring countries.

In July 2015, in order to mitigate treatment interruptions during periods of instability, the country developed a national contingency plan for people on ART, namely provision of two months of ARV drug refills for emergency use. The plan is supposed to be operational from March 2016 and the GF will supply these 'emergency' ARVs.

Alternatives approaches to care are being piloted by MSF:

- **Decentralisation of treatment:** In Zemio, MSF has decentralised ART care to various peripheral clinics. In Carnot, some patients were travelling over 100 km to access treatment and MSF has therefore decentralised care to three different sites outside of Carnot. The same approach is being implemented for Bangonde hospital, near Bangassou.
- **Peer support at health facilities:** In various places, PLHIV are actively involved in HIV activities such as supporting health staff in counselling tasks, tracing patients who are lost to follow-up and providing home-based care. However, this pilot experience suggests that moving from voluntary basis to some form of remuneration may be important for retaining this work force and their motivation.

²⁷ Global Fund data –WHO cohort analysis, June 2015.



- Community-based ARV refills: In 2016, several MSF programs will increase the involvement of PLHIV to support implementation of a community model of ART delivery. This includes collecting drugs on behalf of fellow patients at the health facility as a way of reducing access barriers linked to waiting time, transport constraints and costs. Similar community ARV adherence groups (CAGs) have been shown to significantly improve retention in care in Southern Africa.

The supply chain for key HIV commodities is a major challenge in CAR. Frequent stockouts of ARVs, OI drugs and other commodities are reported at both national and health facility level, which entail serious implications for patients in terms of incomplete and interrupted treatment schedules. The support for last-mile delivery is limited and ad-hoc, nor is there systematic provision of buffer stocks at health facilities to compensate for delays or unexpected supply interruptions. The problem is compounded by difficult road access and security constraints. The Global Fund proposed a nine month buffer stock to compensate for fluctuating needs and supply delays. MSF has facilitated transport of Global Fund supplies from Bangui to peripheral health facilities, demonstrating that NGOs and other agencies could play a crucial role in improving logistics and reducing stockouts even in remote areas.

Local NGOs and patient associations can play an important role in the HIV response. For example, the local NGO RECAPEV has played a particularly active role in trying to reduce stigma over the last 20 years in Bangui. In the current climate of civil unrest and economic instability however, the ability of local NGOs and patient associations to function effectively is hampered by lack of recognition and financial support. Several PLHIV associations that were previously supported by the World Bank saw this support withdrawn at the end of 2012. In addition, the 'watchdog' role by civil society remains limited, in spite of the existence of so-called "relais communautaires" (community networks) throughout the country. This is a missed opportunity, as they can play a key role in monitoring and reporting of problems for rapid responses to stockouts or financial barriers due to user fees.

FUNDING FLOWS

There is a lack of recent and reliable figures on HIV funding in CAR. In 2011, less than US\$100 was allocated overall to HIV care and treatment per PLHIV, with about US\$60 to ARV costs; over 90% of this funding came from international sources.²⁸

The Global Fund, present in CAR since 2004, is the single largest funder of health programs in the country, and has been for many years.²⁹ The GF provides almost all ARVs. The MAP (Multi Country AIDS program) project funded by the World Bank ended in 2012. Several UN agencies support HIV-related activities through coordination of small scale projects. Bilateral agencies, such as the French Cooperation (AFETI) and USAID are also involved, but do not fund the purchase of ARVs. The EC and several EU member states are contributing to health services through a health trust fund -called the 'Bêkou Fund'- but also without funding for ARVs or other specific HIV-related commodities.

The 2013 Global Fund audit of supported HIV, TB and Malaria programs showed that in addition to capacity constraints and poor infrastructure, progress in program delivery was hampered by delayed disbursements, frequent stockouts and lack of reliable data. However, the report also states that these delays had been "exacerbated by disbursement freeze and other fiscal safeguards designed to mitigate the significant risks of operating in CAR" and recommendations were made to revise grant work plans to prioritise live-saving activities and treatment without further delay.³⁰

According to the Global Fund's new approach to so-called 'Challenging Operating Environments' (COE), CAR is able to submit a concept note or a request for reprogramming for continued funding through a lighter process than that which is normally required. The management of the grant has also become better adapted to a changing context, including suddenly emerging problems or opportunities. However, in practice, further improvements are needed, particularly regarding monitoring and supply chain management (last mile delivery). Requests for continued funding should be based on a robust assessment of funding gaps, needs as well as capacities.



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²⁸ Granich R. *et al.* Pattern, Determinants, and Impact of HIV Spending on Care and Treatment in 38 High-Burden Low- and Middle-Income Countries. *J Int Assoc Provid AIDS Care*. 2016;15(1). Available from: <http://www.iapac.org/uploads/JIAPAC-Granich-et-al-HIV-Spending-Analyses-Pre-Print-120115.pdf>

²⁹ This was already highlighted in the MSF report: "Central African Republic: a State of Silent Crisis". *Op.Cit.*

RECOMMENDATIONS

• Strategies to scale up HIV testing

- Assure HIV testing is offered systematically to in-patients, tuberculosis patients and malnourished children. The significantly higher HIV prevalence rates among patients presenting at health facilities provides an opportunity to increase detection and target the offer of life-saving ARVs for those urgently in need of treatment.

• Strategies for boosting ART initiation and improving retention in care

- Encourage other health donors – such as the Bêkou fund – to include funding for essential HIV-related interventions, including ART and other commodities.
- Develop and implement simplified models of care for use outside the capital.
- Improve adherence and retention in care by implementing alternative refill strategies such as peripheral posts for ARV drug distribution, 3 to 6 month ARV drug refills, fast track or grouped ART pick-up in health facilities, and community-based refills.
- Further implement task shifting for testing, counselling, treatment initiation and continuation, patient peer support and patient tracking, including for lay staff.
- Reduce stockouts and drug shortages, in order to limit the risk of treatment interruption or slowing initiation rates, by ensuring adequate buffer stocks at national and health facility level.

• Mitigate access barriers linked to weak health systems and services:

- Provide targeted subsidies to remove out-of-pocket payments for all essential HIV-related services and expand, in particular, access to key entry points for PLHIV such as maternal and child care health, TB and in-patient services.
- Ensure sufficient supplies of all drugs and commodities to allow rapid ART scale up for adults, children and pregnant women, in and beyond the capital.
- Involve PLHIV both at facility and community level and remunerate them adequately. Include a specific budget line in funding proposals for civil society and community based activities.
- Increase capacity for VL and PCR testing, for both EID and viral load monitoring, for early detection of failures through investment in point of care technologies such as Gene Xpert for viral load and early infant diagnosis. Implement feasible transport solutions and explore better use of e-health tools. Meanwhile, practical alternative arrangements are urgently needed outside Bangui, e.g. support for transporting samples to laboratories outside the country where needed.

• Be prepared for and reactive to disruptions:

- Provide patients with a personal buffer stock (for emergency use), with clear documentation of their medical condition and treatment. Provide patients with clear instructions on what to do in case the health facilities cannot assure services and who to contact (phone numbers etc.).
- Ensure the contingency plan –including a contingency stock and pre-determined scenario- is put in place and updated regularly.
- Ensure HIV is taken into account in the emergency phase in all future crises or eruptions of violence or insecurity. The humanitarian cluster system should take HIV treatment on board as part and parcel of the first stage of the emergency response. Include the possibility of ART initiation during crisis.
- Institute a simple re-start ART protocol and preferentially select fixed dose drug regimens that have fewer side-effects and reduce the risks of developing resistance in case treatment is interrupted (such as WHO's recommended fixed dose combination (FDC) of ARVs containing tenofovir, efavirenz and lamivudine or emtricitabine).³¹



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³¹ Vitoria M. et al, Choice of antiretroviral drugs for continued treatment scale-up in a public health approach: what more do we need to know?, Journal of the International AIDS Society, 19:20504, February 2016. Available from: <http://www.jiasociety.org/index.php/jias/article/view/20504> | <http://dx.doi.org/10.7448/IAS.19.1.20504>

CONCLUSION

Years of political instability and civil conflict in the Central African Republic have led to a deterioration of basic health services in the country, and a subsequent destabilisation of the national response to the HIV/AIDS epidemic.

Reduced HIV testing, suspended or delayed treatment initiations and treatment interruptions urgently call for swift and effective catch-up efforts in CAR, especially given the worrying prevalence rates in the country. Population displacement and sexual violence create additional risk factors for the propagation of HIV. Without additional support, existing services cannot cope and cannot assure equitable treatment access for PLHIV. Against a backdrop of significant social stigma and discrimination within the community and within health services as well, measures

that protect PLHIV and support their access to adequate care are needed. Out-of-pocket payments coupled with a multitude of structural challenges constitute major barriers for testing, treatment and care, and need to be urgently alleviated. Appropriate, simplified models of care must be adopted to ensure access to services for all in need.

The HIV epidemic in CAR is far from abating and considerable additional efforts are required to curb it. But the opportunity is there. Various experimental measures and models of care for supporting and preserving effective HIV care during crisis situations are being explored. These innovative developments alongside the presence of numerous humanitarian organizations, the UN agencies, the Global Fund and bilateral donors, constitute an opportunity for the country to scale up HIV services and make better headway towards the 90-90-90 targets.

Dr Wilfried Mbolissa, HIV/TB doctor for MSF in Carnot

In February 2011, when MSF started its activities in Carnot, only the patients supported by us had access to free services. But this quickly led to problems: as everybody knew that those who didn't have to pay were HIV positive our patients were discriminated against. Therefore MSF decided to take over the internal medicine ward from May 2013 onwards to mitigate the discrimination.

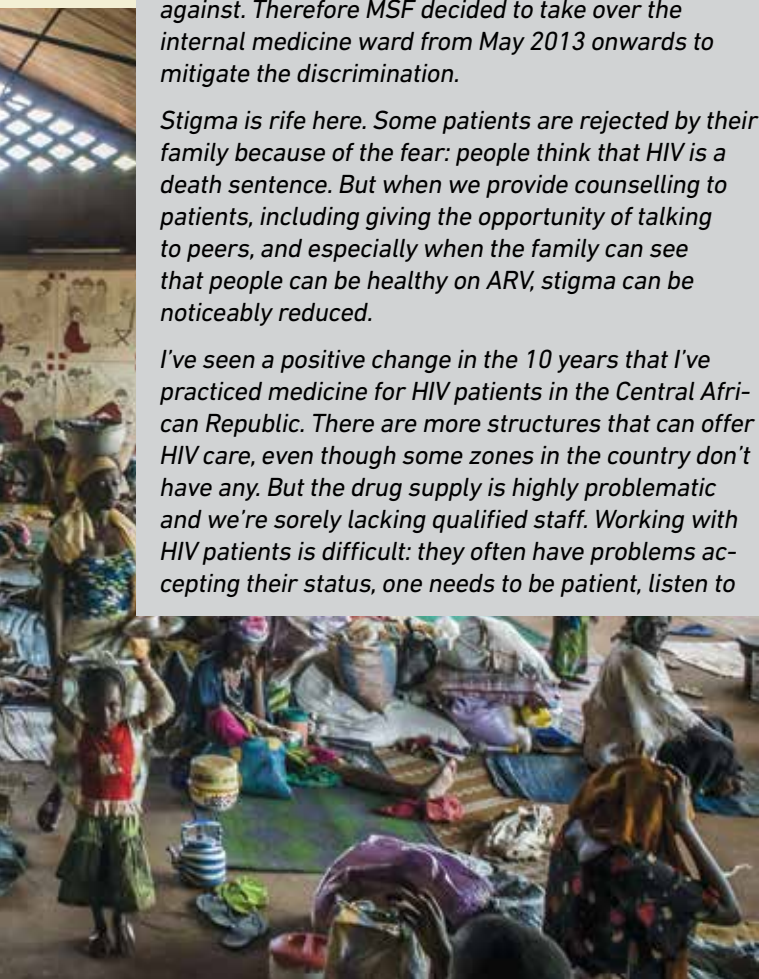
Stigma is rife here. Some patients are rejected by their family because of the fear: people think that HIV is a death sentence. But when we provide counselling to patients, including giving the opportunity of talking to peers, and especially when the family can see that people can be healthy on ARV, stigma can be noticeably reduced.

I've seen a positive change in the 10 years that I've practiced medicine for HIV patients in the Central African Republic. There are more structures that can offer HIV care, even though some zones in the country don't have any. But the drug supply is highly problematic and we're sorely lacking qualified staff. Working with HIV patients is difficult: they often have problems accepting their status, one needs to be patient, listen to

them, and have a real passion to bring care despite the difficulties. We need to establish a long term relationship with our patients, we share difficult moments with them. The professional reward comes when we can instill a desperate person with a will to live and fight. This is beautiful, this is what keeps me going. Task shifting, which we have introduced, can certainly ease the work for doctors and increase the overall capacity to respond.

In the past four years we have initiated a cohort of over 1800 patients. The recent political instability caused major problems for us: either people left the area and dropped out of care, or were too scared to come to the health center to get their medication. Because it has become so difficult to access care in general in CAR, we've noticed a drastic increase of hospitalization in 2015. Nowadays 70% of inpatients in the internal medicine ward are here for HIV/AIDS related illnesses, a fourth of them because of tuberculosis coinfection.

Most of our patients who came back in HIV care were very sick, sometimes critically so. Two days ago we lost a patient who had abandoned his treatment for over a year. He died within a few hours of being admitted, so quickly that we could never even ask him why he dropped out of care.



Internally displaced people in Carnot, 2014

MSF has been working in CAR since 1997. In MSF-supported facilities, some 4,813 patients are on ART, or about 19% of the national cohort, including in prefectures with the highest HIV prevalence. Patients are offered free of charge diagnosis, treatment and adherence support. Provision of HIV services in CAR is challenging, given the recurrent bouts of violence and displacement, further compounded by a health system in very poor state.

Epidemiology

Number of people living with HIV	450,000	[400,000 - 490,000]
Pregnant women living with HIV	26,000	[52,000 - 66,000]
Children aged 0 to 14 living with HIV	59,000	[20,000 - 31,000]
Deaths due to AIDS	24,000	[25,000-33,000]
New infections per year	29,000	
Adults aged 15 to 49 prevalence rate	1.0%	[0.9% - 1.2%]
HIV prevalence in key populations:		
-Sex workers	6.9%*	
-Prisoners	11%	
-MSM	9.5%	
-TB patients	14%**	

Source: UNAIDS 2014 data, available from <http://aidsinfo.unaids.org/>

Source*: GARP Report 2015

Source**: WHO TB report

Note: Data and information collection methods vary widely according to the source. Caution in their interpretation should therefore be exercised.

DEMOCRATIC REPUBLIC OF CONGO (DRC)

HIV TREATMENT OUT OF REACH FOR MOST

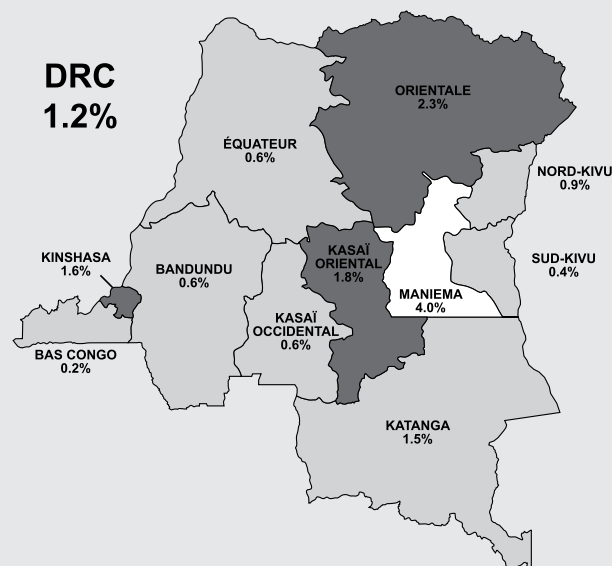
OVERVIEW

Nearly two decades of war and violence have left the DRC fragile, institutionally weak and in considerable need of reconstruction. It is ranked as one of the poorest countries in the world. The security situation is improving overall but it still remains tense, particularly in the eastern provinces with recurring violence and internal displacement. Poverty is pervasive throughout the country, with 64% of the population living below the poverty line.¹

The country's health indicators reflect major problems in living conditions and health service coverage.^{2,3} Recurring epidemic outbreaks of measles, cholera, malaria and others negatively impact the population's health status. About US\$13 per capita was spent on health in 2012; of which 43% was paid by households and 15% by the government. In addition to insufficient health sector financing, existing health facilities face important logistical and infrastructure constraints, coupled with weak supervision and oversight.⁴ Policies and plans have a modest impact on actual health service delivery, in particular in the rural periphery. Scarce financial resources in the public health services lead to a limited offer of care and to 'coping' mechanisms by health workers that create systemic inefficiencies and financial barriers that deter people from using services. An enormous variation exists in local healthcare provision arrangements; together, FBOs and NGOs provide a large portion of healthcare.⁵

Despite a relatively low national HIV prevalence (1%), DRC, due to its large population, is home to 7% of PLHIV in the West and Central Africa region. The country has an estimated 450,000 PLHIV and sees 29,000 new infections each year⁶. Variations in HIV prevalence exist inter-regionally (Figure 1), between urban (1.9%) and rural (0.8%) areas and between men (0.7%) and women (1.6%).⁷ Antenatal data indicate that certain regions are more affected than others, with prevalence above 3.5% among pregnant women in some provinces.

Figure 1:
Estimated HIV prevalence
(15-49 years of age) by province, DRC.



Source : Ministère du Plan et du Suivi de la Mise en oeuvre de la Révolution et la Modernité (MPSMRM); Ministère de la Santé Public (MSP) and ICF International. 2014. Democratic Republic of Congo. Demographic and Health Survey 2013-2014. Key findings. Rockville, Maryland, USA. MSP and ICF International.

- ¹ World Development Indicators for DRC, World Bank. Available from: <http://data.worldbank.org/country/congo-dem-rep>.
- ² Democratic Republic of the Congo: WHO statistical profile. World health organisation. Available from : <http://www.who.int/gho/countries/cod.pdf?ua=1>
- ³ Ministère du Plan et du Suivi de la Mise en oeuvre de la Révolution et la Modernité (MPSMRM); Ministère de la Santé Public (MSP) and ICF International. 2014. Democratic Republic of Congo. Demographic and Health Survey 2013-2014. Key findings. Rockville, Maryland, USA. MSP and ICF International.
- ⁴ Democratic Republic of Congo Country Operational Plan 2014. Executive summary. PEPFAR/US. Available from : <http://www.pepfar.gov/countries/cop/240136.htm>
- ⁵ Hill *et al.* The "empty void" is a crowded space: health service provision at the margins of fragile and conflict affected states. Conflict and Health 2014, 8:20 Page 2 of 10; Available from: <http://www.conflictandhealth.com/content/8/1/20>
- ⁶ UNAIDS 2014 data, available from <http://aidsinfo.unaids.org/>
- ⁷ United States Department of State, DRC Country Operational Plan (COP); Strategic Development Summary.COP Fiscal Year 2015.

PROGRESS TOWARDS THE 90-90-90 TARGETS

In principle, DRC has committed fully to the UNAIDS goal of 90-90-90 by 2020. But there are still major challenges ahead in its implementation and, in particular, the application of the 2015 WHO guidelines that emphasize early ART for all PLHIV regardless of clinical status.

Coverage rates	2013	2014
% tested	4	
% of pregnant women in PMTCT	33	47
% of PLHIV on ART*	18	23
% of children on ART	8	14
% co-infected people TB-HIV on ART	18	48
% retention at 12 months**	78	

Source: PNLS⁸, UNAIDS⁹ and WHO Global TB report 2014.

Source*: The number of people on ART is likely to be overestimated, as loss-to-follow-up is mostly not taken into account.

Source**: Data on retention cited in the 2014 PNLS report refer to data on MSF supported Kabinda CTA in 2012. Regarding retention, data vary widely. As a point of comparison, retention rates at 12 months (2013) in MSF programs ranged from less than 50% up to 78%.

TARGET 1: BY 2020 90% OF PLHIV WILL KNOW THEIR STATUS

Despite recent DHS data indicate that HIV testing has doubled since 2007, nearly 80% of women and 84% of men have still never been tested.¹⁰

During a HIV testing campaign in June 2015, national and international partners tested 42,150 people in Goma, Bukavu, Mbuji-Mayi and Lubumbashi. In December 2015 the health authorities launched countrywide three months of intensified HIV testing¹¹ and in Goma in January 2016, MSF partook in mobile voluntary counselling and testing (VCT) during which 1,200 people were tested (67% men), among which the HIV positivity rate was just over 2% (3.8% for women).

Testing and counselling: Most HIV testing is provider initiated, but not routinely offered, and is mainly used as a diagnostic tool for people already ill. Although an HIV test itself is free-of-charge, because it is offered as part of the health facility-based services, patients often have to pay for the consultation (equivalent of US\$2-5) and other examinations preceding the test.¹² Stand-alone VCT

services are mostly free-of-charge, but the number of available sites has decreased since 2009.¹³

Some of the reported barriers to health facility-based HIV testing include lack of confidentiality, patient fees, low staff motivation and shortages of HIV tests. Different sources reveal the following:

- HIV testing is not systematically offered in health facilities, which means missed opportunities, for instance for TB patients, STI patients, malnourished patients, and hospitalized patients in internal medicine.
- When MSF offered HIV testing and counselling (HCT) to inpatients in the medical wards of three Kinshasa hospitals in December 2012, 90% said they had never been offered an HIV test before.
- When offered, HIV testing uptake is high and HIV positivity rates are high. In the abovementioned hospitals, only 3% of patients refused an HIV test; the HIV positivity rate was 9% overall among adult patients and as high as 13% among in-patients in one hospital. In MSF-supported clinics in Kinshasa, 15,686 patients were tested in 2015 (HIV positivity rate: 7.5 %)¹⁴
- Only 44% of TB patients know their HIV status.¹⁵
- In the MSF-supported points de distributions communautaires (called 'PODI') in Kinshasa (see box), PLHIV associations offer targeted HIV Testing Services (HTS). In 2015, this allowed 2,054 persons to be tested (HIV positivity rate: 19%).
- A survey by the national HIV programme indicated that 9% of PLHIV tested had their serologic status revealed to others by health workers without their consent.¹⁶
- A survey in Kinshasa in 2014 showed that out of 94 facilities providing testing, 59% had a long lasting stockout.¹⁷

The national policy allows HIV-testing and counselling to be done both by nurses and lay workers, which should facilitate the rise of HIV Testing Services (HTS).

Testing among pregnant women: Although HIV testing among pregnant is a national priority, according to the EDS-RDC II (2014), only 13% of pregnant women reported being tested and counselled during antenatal visits. HIV positivity rates among pregnant women range from 1.2% to 3.5% in some provinces.¹⁸ In PEPFAR-supported sites, on average 10 HIV-positive women are detected per year per site.¹⁹ Treatment literacy and peer support for mothers is still limited in most places.

⁸ Rapport sur l'état d'avancement de la réponse à l'épidémie de VIH/SIDA (2014). PNMLS, Mars 2014. Kinshasa, RDC.

⁹ UNAIDS 2014 data, available from <http://aidsinfo.unaids.org/>

¹⁰ DHS Democratic Republic of Congo 2013-2014: Key findings

¹¹ RDC : Le PNLS annonce la campagne de dépistage du SIDA. Publié le 8/12/2015. Radio Okapi, DRC. See : <http://www.radiookapi.net/2015/12/08/actualite/sante/rdc-le-pnls-annonce-la-campagne-de-depistage-du-sida-partir-du-10>

¹² Henri Mundongo Tshamba et al., Cost of hospital care for HIV/AIDS patients in three general reference hospitals in Lubumbashi, DRC: a prospective study. PanAfrican Medical Journal 2013. 15; 76. See : <http://dx.doi.org/10.11604/2Fpamj.2013.15.76.2638>

¹³ PNMLS, Kinshasa, Plan Stratégique 2014-2017, Juin 2014. Annexes. Page 55. Available from: http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/democratic_republic_of_congo/plan_strategique_national_2014-2017.pdf

¹⁴ MSF, Annual Report Projet Sida, 2015.

¹⁵ United States Department of State, Op.Cit.

¹⁶ PNLS, UCOP+, ONUSIDA, PNUD. Index de stigmatisation et de discrimination des personnes vivant avec le VIH. Rapport d'enquête. RDC. Novembre 2012. R

¹⁷ MSF, Empty Shelves, Come Back Tomorrow. ARV stock outs undermine efforts to fight HIV, November, 2015. Available from: https://www.doctorswithoutborders.org/sites/usa/files/msf_out_of_stocks_low_per_pages.pdf.

¹⁸ National program to fight HIV/AIDS, PNLS.

¹⁹ United States Department of State, Op.Cit.



Early Infant Diagnosis (EID): In 2014, only 5,936 exposed babies of 12,294 pregnant women on ART were included in the follow-up; 59% of these children received a PCR test, 15% of them before two months of age.²⁰ The HIV positivity rate was 6.6 %.²¹ There are currently five laboratories offering EID and VL testing. Sending dried blood samples to these laboratories is problematic, because of the logistics (transport, supplies etc.) and slow subsequent communication of results by the labs. MSF teams in Goma reported three to six month delays. Some MSF programmes have resorted to sending their samples for EID to South Africa. The scale-up of VL/EID is a high priority for the health authorities and supporting partners, and a three-year action plan aimed at increasing the number of VL testing sites to 12 has been developed. Together with the health authorities, PEPFAR, GF and UN agencies are exploring investment in additional laboratory capacity for EID and a sample transport system.

TARGET 2: BY 2020, 90% OF PLHIV WILL ACCESS ART

In 2014, 101,324 PLHIV were reported to be on ART, equating to a national ART coverage of 23% -among the lowest worldwide.²² The capital, Kinshasa, has a higher coverage, at 41% (26,000 out of an estimated 63,343 PLHIV are on ART), but this is still low.²³ Poor coverage is a consequence of limited availability and accessibility of services.

Long distances and lack of public transport render access to many ART sites a challenge. For instance, in the Mweso health zone (North Kivu), the MSF-supported referral hospital was the sole structure that offered ARVs.²⁴ Up to 65% of patients have to walk for over a day to reach the hospital. The volatile security situation means that many PLHIV in the area have to constantly relocate, making regular access to ART sites even more difficult.

PLHIV fear disclosing their status to their employers or family. Stigma remains a major issue, especially towards women, who can face physical aggression, threats, or rejection by their husband, family members or community.

²⁰ PNMLS, Rapport sur l'état d'avancement de la réponse à l'épidémie de VIH/SIDA (2014), Mars 2014. Kinshasa, RDC.

²¹ PNLS, Plan de développement des Laboratoires : passage à l'échelle pour CV et diagnostique précoce pour enfants (EID) en RDC, 2015.

²² UNAIDS 2014 data, available from <http://aidsinfo.unaids.org/>

²³ PNMLS. Profile VIH province de Kinshasa, Available from: [http://www.pnmls.cd/doc/Profil%20VIH%20Kinshasa%20\(2\).pdf](http://www.pnmls.cd/doc/Profil%20VIH%20Kinshasa%20(2).pdf)

²⁴ Following a security incident end of 2015 MSF teams had to leave Mweso.



Even in health structures, stigma is present. In a study in health facilities of Goma and Karisimbi, North Kivu, up to 20% of PLHIV interviewed reported stigmatising attitudes in health care workers in.²⁵

There is often a long time lapse between diagnosis and treatment start, exacerbated by delays in CD4 count and baseline laboratory testing. Compounding the situation further, patients are sometimes required to pay between US\$15 and US\$30 for CD4 count testing.

At health centres, low nursing wages (starting at about US\$96 per month) mean that user fees are the main source of revenue. This renders the 'free access to care' policy for PLHIV essentially meaningless. In Goma for example, HIV testing is free, but US\$2 is charged for a consultation, post-exposure prophylaxis costs up to US\$50 and a US\$20 penalty fee applies to patients who discontinue treatment. In Lubumbashi in 2013, the direct costs incurred by hospitalised HIV patients were on average found to be just over US\$200, exceeding patients' monthly income in 63% of cases. Drugs accounted for 35% of these costs and paraclinical examinations, 44%. The more severely ill a

patient, the higher the costs; patients with opportunistic infections incurred additional costs as high as US\$31.

Many PLHIV start ART late, when they are already seriously ill. DRC has adopted the 2013 WHO guidelines, but early start of ARV remains difficult. In MSF-supported health facilities in Kinshasa, in 2015 the median CD4 count at start of treatment was 212, while 46% of patients had CD4 counts below 200 at initiation. Late presenters have an increased risk of dying. At the MSF supported Kabinda Hospital in Kinshasa, one in four hospitalized HIV-patients died after admission (39% within 24 hours) in 2015. The median CD4 count of these in-patients was 76 in 2014.²⁶

Patients with opportunistic infections (OI) have limited access to the necessary drugs. Only a small proportion of donor funding (e.g. of Global Fund grants) goes to OI drugs, while inappropriate use of these drugs create further shortfalls, leading to incomplete or sub-quality treatment and high out-of-pocket costs to patients.

Countrywide, the number of ART treatment sites has increased considerably over the past few years from

²⁵ Observatoire des cas de stigmatisation et discrimination dans les structures de PeC et dans la communauté. ZS Goma & Karisimbi, Septembre 2014 à Décembre 2015. UCOP+ Nord Kivu in collaboration with SCF.

²⁶ Machako M. Forte mortalité intra-hospitalière de PVVIH à Kinshasa: quelles stratégies pour y remédier? Mémoire présenté pour Maitrise en Santé publique- contrôle des maladies à l'institut de Médecins Tropicales à Anvers, Belgique. Juin 2015.

300 sites (in 2009) to 1315 sites (in 2014).^{27,28} However access barriers and supply difficulties hamper to reach the full potential of this increase in sites; an average of 22 new ART initiations annually per site is reported. At the health facility level, stockouts of ARVs and other essential commodities are frequent, impeding both retention in care and delaying ART initiations.

National data from 2013 reported around 14,000 new ART initiations per year. In a country that has an estimated 29,000 new infections per year however, the rate of ART initiation needs to be accelerated and delays in ART start need to be reduced.

The country adopted the 2013 WHO guidelines, including implementation of tenofovir-based regimen as the first line ARV (replacing AZT). While supplies arrived in September 2015, by March 2016 the national roll out of the new drugs has still not yet been implemented. In North Kivu this better drug combination is reserved for pregnant women when available.

PMTCT: ART coverage among pregnant women has risen from 3,771 in 2010 to 12,294 (52.2%) in 2014²⁹, reaching 40% of the planned objective. DRC is one of the 22 priority countries for the elimination of mother to child transmission (E-MTCT). MSF's experience of EMTCT however reveals a multitude of challenges related to retention in care including stigma and poor community awareness of HIV, fear of disclosure, delayed EID, lack of counselling services, and poor integration into general HIV care services once mothers are discharged from PMTCT.

Children: Following the withdrawal of financial support by UNITAID, the number of children on ART dropped from 6,238 in 2011 to 4,751 in 2012. In 2014 there were 8,500 children (under age 15) reported on treatment, which indicates that coverage remains low at 13.9%. According to the 2013 WHO guideline, a test and treat approach should be adopted for children below five. Shortfalls and stockouts in paediatric ART hamper initiation and quality of care. In particular for smaller children, this creates dosage problems. There are still only a limited number of sites for children with HIV; in North Kivu for instance one hospital provides paediatric ART.

TARGET 3: BY 2020 90% OF PLHIV ON ART WILL HAVE AN UNDETECTABLE VIRAL LOAD

The country has committed to a roll out of systematic viral load (VL) testing by 2017. Yet some provinces are currently without access to any VL testing possibility, as is the case in North Kivu for instance. Viral load testing is limited primarily to health facilities close around five laboratory sites (three in Kinshasa, one in Mbandaka and one in Lubumbashi) or when able to send samples there. Moreover, not all laboratories can accept DBS.³⁰ National data on the level of successful control of the virus in PLHIV on ART will not be available before end 2016.

Patients report that drug stockouts, frequent clinic visits, long waiting times and financial barriers (user fees and transport costs) hinder retention in care. However, retention is significantly improved by various measures, including reducing the frequency of drug refills, peer support, counselling for adherence and early tracing of patients who miss appointments. Figures from MSF-supported health facilities show retention at 12 months ranging from less than 50% up to 78%, depending on the context (2013 data). However, in Kinshasa, a pilot scheme where PLHIV obtain their ART in so-called Points de Distribution Communautaires or PODIs -less frequent and closer to home- led to very positive results (see Box).

PODI – Points de Distribution Communautaires (Distribution Points)

At the end of 2010, MSF, together with a local NGO, established community ARV distribution points in Kinshasa to bring ARV refills closer to where PLHIV live. These points are managed by PLHIV trained to provide ARV refills, adherence support and basic health follow-up. Stable patients are eligible to participate in the program. They receive their three months of ARV refills and report annually for clinical consultation and CD4 count monitoring. As of July 2013, 2,162 patients were enrolled in the PODI program, representing 43% of the active cohort. At 12 months, 89% had been retained in care. Further analysis showed that transport costs for patients were dramatically reduced (three times less than the cost of accessing traditional health services) and waiting times slashed by seven. Another positive effect of the PODIs is the reduction in work load on the health facilities.

PODIs also offer free HIV testing and counseling. Community members refer people for testing. In 2015, 1,947 people were tested through the PODIs with 376 testing HIV positive (19%).³¹ Given the relatively high positivity rates, this seems to be a very efficient means of detecting HIV.

²⁷ Rapport de mission de mise à jour des infos stratégiques des programmes VIH dans les sites appuyés par le Fonds Mondial en RDC. PNUD /FM 2012.

²⁸ Biayi F. Plan d'Approvisionnement Médicaments et Intrants pour la Lutte contre le SIDA. Juin 2013. Ministère de la Santé, Secrétariat Général, Kinshasa, RDC. Available from: <http://www.asrames.com/wp-content/uploads/2012/04/Plans-dApprovisionnement-des-M%C3%A9dicaments-et-Intrants-de-lutte-contre-le-VIH-SIDA.pdf>

²⁹ PNLS, Rapport annuel, Op. Cit.

³⁰ Some sites use the Abbott platform but testing based on DBS have not been validated.

³¹ MSF 2015 Kinshasa activity report.

Besides the PODI approach, several national and international NGOs provide peer support groups. MSF started collaboration with PLHIV groups in Baraka (South Kivu) in 2015. The groups work closely with the clinic teams. They support tracing of people who miss appointments and provide home-based support for patients struggling to accept their HIV status or those with adherence issues, especially treatment failure cases.

Loss to follow up can be underestimated as patients that interrupt their treatment often present as new patients. Through in-depth interviews at the MSF-supported Kabinda hospital, it was discovered that 70% of patients admitted they were previously on ARV and about half had interrupted their treatment for more than three months.³²

Other factors that affect retention in care include people leaving the area for extended periods of time to work in the mining industry, as well as insecurity in conflict affected areas. In areas under chronic conflict, a contingency plan (ensuring emergency supplies of ART) at patient, health center, local, national and international level is of key importance, as demonstrated by MSF in various conflict settings, including eastern parts of the DRC.³³



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³² Machako M. *Op. Cit.*

³³ O'Brien D. P. *et al.*, Provision of antiretroviral treatment in conflict settings : the experience of MSF. See Conflict and Health 2010 ; 4 ; 12. Available from: <http://conflictandhealth.biomedcentral.com/articles/10.1186/1752-1505-4-12>

The impact of frequent stockouts of ARVs, testing kits and other HIV care commodities

In DRC, low stock and stockouts of HIV-related commodities is a frequent problem leading to patients being unable to start or continue treatment; such issues demand burdensome coping mechanisms from patients and health staff. Likewise, poor management in intermediate medical stores, together with delivery issues, means that in some instances ART and other commodities do not reach patients before they expire.³⁴

A snapshot analysis of 94 health facilities covering more than 70% of the ART cohort in Kinshasa indicated frequent and long-lasting stockouts of ARVs, OI drugs and HIV tests.³⁵ In the first quarter of 2015, 77% of these facilities had experienced at least one ARV drug stockout. At the time of the evaluation, 45% of facilities were experiencing a stockout of TDF-3TC-EFV. Although equivalent medicines were available in the city, an estimated 1,300 patients presenting over a three-month period were sent home without ART. In addition, stockouts of test kits over a three-month period resulted in an estimated 4,000 patients unable to be tested. Further analysis showed that for 45% of items out of stock at health facility level, the same drug was available in the zonal depots.³⁶ One of the main issues is that there is no budget foreseen to effectively bridge last mile delivery to bring the medicines to patients.

The situation in the rest of the country, where even greater logistical challenges exist, is likely even worse. An evaluation done by patient organisations (and Médecins du Monde) in Nord Kivu found that over 12 of 34 health facilities visited had ARV drug stockouts, of which four facilities were missing all ART components.³⁷ Frequent stockouts of drugs for opportunistic infections (in 10 out of 13 health zones) and test kits were also reported.

In 2014, less than 8% of patients in DRC had access to the most appropriate one-pill-a-day regimen (a

³⁴ Fontaine A. En RDC, une gestion chaotique des stocks a un impact sur les soins dans la lutte contre le Sida. AIDSspan Numéro 16; 24 Juillet 2015. Available from : <http://www.aidspace.org/node/3332>

³⁵ MSF & PNLS, 2015. Les patients face aux ruptures de stock: Etat des lieux sur la disponibilité des intrants essentiels pour la lutte contre le SIDA à Kinshasa. Available from: https://www.msf.org/sites/msf.org/files/msf_out_of_stocks_low_res.pdf

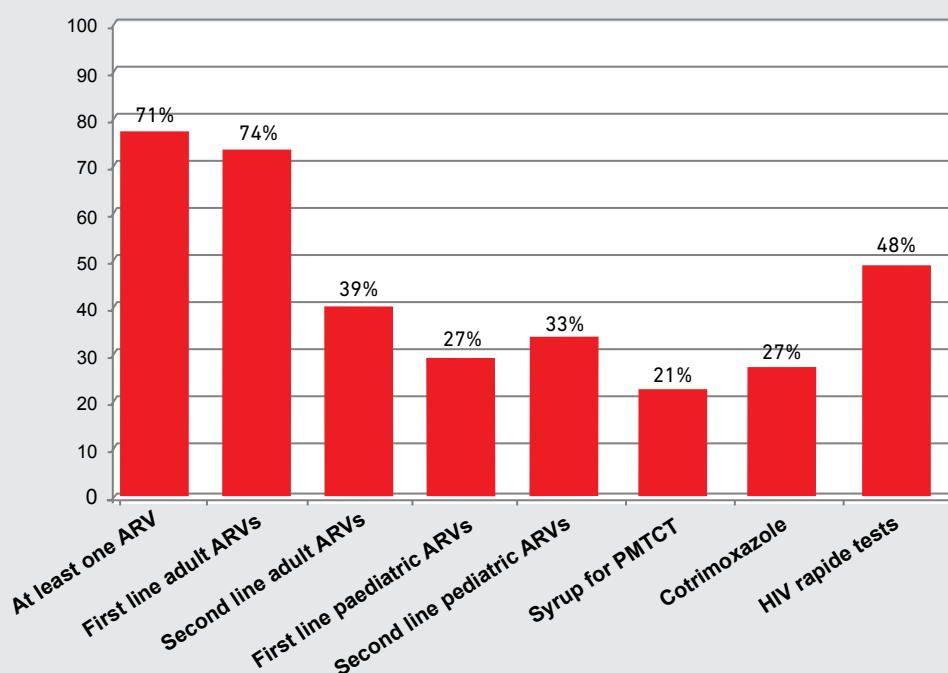
³⁶ MSF, Empty shelves. Come back tomorrow., *Op. Cit.*

³⁷ Paroles des usagers et des prestataires sur l'accessibilité et la qualité des services VIH, Février 2015, MDM.

fixed dose formulation (FDC) of TDF-3TC-EFV). Currently mainly HIV positive pregnant women have access to this first line regimen as the country started to roll out option B+ in 2013. The countrywide shift from AZT to TDF-based regimen has been delayed.

The current system is vulnerable to stockouts, particularly in light of major changes planned in ART regimens/protocols, VL scaling-up efforts, as well as shifts in donor support to different geographic locations foreseen in 2016. And yet, buffer stocks at health facility level are limited to less than one month of average drug consumption. At national level there is no buffer stock available for paediatric ARVs. No specific contingency plan exists, neither a contingency stock to deal with these challenging transitions.

Figure 2:
Proportion of health facilities reporting at least one stock out during assessment visit of 94 sites (or during previous 3 months) in Kinshasa, DRC (2015).



FUNDING FLOWS

In 2012, overall HIV spending in DRC was just over US\$229 million, 20% higher than in 2011. About US\$2.7 million (1.2%) was contributed by the government, most of which went towards strengthening health systems, surveillance and program coordination; no purchase of ARVs or HIV tests was included. Major disbursement problems arose in 2012 and 2013, with not more than 10% of the allocated HIV budget being disbursed.

Patient out-of-pocket payments amounted to 38% of all HIV expenditure in 2012³⁸.

The largest part of the HIV budget is covered by international donors. Since the withdrawal from HIV funding of the World Bank's MAP program in 2011 and UNITAID in 2013, the Global Fund (GF) is currently the main HIV funding source in the DRC, followed by USG/PEPFAR. In 2012, the GF financed 90% of ARTs purchased (ART provision for 65,000 of the 76,000 patients on treatment).^{39,40} The remaining ART gap is funded by PEPFAR and others, including UNICEF (PMTCT) and MSF. No other bilateral donors contribute significantly to ART scale-up. The latest proposal submitted to the GF has included provision of ARVs for all existing patients on treatment plus an additional 94,126 patients by 2017.

PEPFAR's policy to direct resources towards so-called 'hot spots' means that from 2016 onwards, PEPFAR-funded interventions will focus on urban areas and key populations in Kinshasa, Kisangani and Lubumbashi. This implies important shifts in the planned allocation of health zones to PEPFAR and GF, which has the potential for gaps and overlaps in continuity of care.

Funding for drugs to treat opportunistic infections is very scarce, leading to major shortages at health facility level and high out-of-pocket payments.

Finally, while local NGOs can play an important role in HIV service delivery, funding constraints have reduced their capacity. NGOs that previously provided free ARVs for example now require payment from patients.⁴¹ Patient associations face the same problems, which adversely impact their institutional capacity, governance and activism role.

³⁸ Rapport sur l'état d'avancement de la réponse à l'épidémie de VIH/SIDA (2014). PNMLS, Mars 2014. Kinshasa, RDC. With reference to REDES report 2011-2012.

³⁹ *Ibid.*

⁴⁰ United States Department of State, Fiscal Year 2015. DRC Country Operational Plan (COP); Strategic Development Summary, 2015

⁴¹ Freeman A. *et al.*, Patient Outcomes in Lubumbashi, Democratic Republic of Congo After a Disruption in HIV Care Due to Decreased Global Fund Appropriations. *AIDS Behav* (2014) 18:2135–2143.



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RECOMMENDATIONS

In elaborating its fast track plan, DRC should maximise its efforts to build upon and rapidly expand the positive pilot experiences in the country. Mobilisation of all relevant actors around this fast track framework is critical to ensure implementation and support of the strategies that will make the difference from day one.

Potential gamechangers to fast tracking 90-90-90

- Strategies to scale up HIV testing
 - Increase the number of sites that offer free-of-charge testing and counselling, involving NGOs, patient associations, and community centers.
 - Ensure that HIV tests are offered at health facility level systematically free-of-charge.
 - Ensure regular targeted testing where HIV-positivity rates are expected to be higher, such as among hospital in-patients, TB patients, STI patients and malnourished patients, as well as in sites where patient associations offer services. Additionally, family testing for all PLHIV already under treatment and those newly initiated should be systematized.
- Strategies for boosting ART initiation and improving retention in care



- Accelerate implementation of the WHO ‘treat all’ guidelines, including early initiation irrespective of CD4 count or clinical stages. Less ill patients require less intensive clinical follow up and can be quickly referred to ARV refills at community level.
- Establish ART initiation centres in selected facilities, based on patient concentration and experienced staff. In these initiation centres, uninterrupted supplies, targeted counselling and peer support can be assured and early ART initiation be accelerated. Once stable, patients can be referred to the community for ARV drug refills and annual VL monitoring.
- Mitigate access barriers linked to weak health systems and services:
 - Apply a strict no pay policy for patients. Ensure all essential elements of HIV care are guaranteed free-of-charge to patients, including tests and clinic visits required to access ARV. Explore the possibility to provide patients with vouchers that assure free-of-charge services. Assure sufficient OI drugs are made available free-of-charge and provide funds dedicated for hospitalization costs.
 - Decrease the frequency of clinic visits and drug refills for stable patients on ART in order to improve retention in care.
- Rapidly roll out PODIs, develop other fast track drug refill circuits for patients, and support community-based ARV refill initiatives and peer support.
- Ensure that lay workers who support patients’ ART initiation and adherence - in and beyond health facilities- are trained, recognized and remunerated.
- Assure sufficient availability of ARV and essential commodities at health facility level through enhanced supply management and last mile delivery; avoid drug stockouts through buffer stocks and larger refills that increase patient autonomy; establish a rapid order system with an emergency stock for ARV, OI drugs and lab reagents.
- Close the treatment gap in ART for children
 - Increase availability of EID through a combination of point-of care methods and transport of DBS samples to the capital or even outside the country; facilitate faster communication of results through SMS, phone or email technology where possible.
 - Scale-up paediatric ART by prioritizing treatment for children at all levels, offering diagnostic tests and ART through more sites, provide specific training to health workers, develop a task shifting model specific for paediatric care, elaborate a standard care package (including adapted nutritional care). A specific approach for counseling of children, adolescents and parents to facilitate disclosure and improve retention is also needed.
- Involve and support patient associations, NGOs and civil society
 - Create a network of HIV services that involve civil society, patient associations, faith-based organisations (FBO) and NGOs that facilitate referral and linkage to care.
 - Organise independent monitoring of availability and accessibility of care to PLHIV. Support patient associations in monitoring ‘free access to care’ policies and the availability of health facility commodities (as part of an early warning system for low stocks).
- Be prepared for and reactive to disruptions
 - Introduce simplified models of care that are appropriate and can be sustained in conflict prone settings. Prepare programmes and patients for possible interruptions of services (e.g. by assuring buffer stocks, providing patients with ART for longer periods of time and patient health cards).
 - Anticipate, determine and organize scenarios for continued ART delivery with a network of providers and agencies, including training of staff, plans to rapidly mobilise human and financial resources; a contingency stock for ART and other essential commodities; a central point for information and communication to advise PLHIV (e.g. toll free phone number).

CONCLUSION

Reaching the UNAIDS targets of 90-90-90 at a worldwide level will require that countries like the DRC be placed at a higher level of priority and urgency, given the number of PLHIV still left out of HIV care and given the complexity of contexts prone to conflict.

The DRC has achieved some important improvements, but there is still a long way to go. Strategic and proactive measures are needed to hasten the pace of ART scale up, increase retention in care and ensure that the 2015 WHO guidelines are implemented without further delay. Meanwhile, progressive efforts need to ensure that conflict prone areas are not neglected in HIV programmes.

Integrating HIV services into the existing health system without mitigating the current barriers to accessing care will impede the fast track approach that is needed. To improve patient outcomes and programmatic results, much greater emphasis on community service delivery is needed. Such approaches will not only reduce the burden on patients and overstretched health facilities alike, but will improve uptake and retention in care by bringing services closer to the people who need them.

Dedicated ART initiation centers in selected facilities, with quality services free-of-charge offered by experienced motivated staff can be combined with less frequent follow up of stable patients at community level. The active involvement of local civil society (NGOs and patient associations) will be crucial to complement care offered at health facility level, community initiatives and monitoring of access and quality of care provided. In order to support the implementation of these strategies increased political and donor interest will be needed to cover the existing gap.

A rapid but realistic scale-up plan is urgently needed for the DRC, one that takes into account the reality of the country's contextual diversity and complexity. Without a sense of urgency towards acceleration of scale up, the fragile gains achieved in the battle against HIV/AIDS in the country are at risk. The epidemic will outrun the response and widening treatment gaps will bear a heavy human and financial toll.

MSF has been working in DRC since 1981, providing HIV services since 1996 and ART since 2002.

In collaboration with the Ministry of Health, the MSF projects currently provide support to 6211 HIV patients or around 5% of the national cohort in 2015.

In Kinshasa, MSF runs an HIV hospital, supports HIV-care in 2 other hospitals, 5 health centres and 3 PODIs, offering diagnosis, treatment and adherence support. MSF is also supporting HIV treatment and care for in- and out-patients in other health facilities, such as in Virunga, Goma, Masisi, Mweso, Rutshuru, Kimbi, Baraka, etc.

Elise and Philomène : two faces of the fight against HIV in the DRC



Philomène – living positively

47 year old Philomène contracted HIV 14 years ago whilst receiving a blood transfer in a Kinshasa hospital after a miscarriage. Her HIV-negative husband remained supportive to the woman he loved. The couple attended several long sessions of information on the disease, which guided them on how to lead a normal family and love life.

As Philomène was enrolled in a successful PMTCT program, she and her husband became parents of two children born free of HIV. They've also greeted into their own family a young HIV positive girl whom they care for as their own child. Philomène is now a dedicated activist within the Congolese community group RENOAC. The courageous woman helps her countrymen to better understand HIV and fight stigma.

Elise – the failures of the system

As her mother Agathe was never screened for HIV and therefore was not enrolled in PMTCT, Elise was born HIV positive. Both mother and child discovered their status six years later, following the death of Elise's father of AIDS-related illness. Because of lack of information and qualified counselling, Agathe gave ARV treatment to her daughter in an erratic manner, and Elise developed a resistance to the first line of antiretroviral drugs. She had to switch to the second line ARV drugs which have heavier side effects and are much more difficult to digest, making it an even bigger challenge for her to fully benefit from the life-saving medication – made worse because the unavailability of paediatric drugs meant she had to take adult medications.



In late 2014 Elise was admitted in MSF's Kabinda hospital in Kinshasa. Her inadequate treatment regimen had taken such a heavy toll that the 12 year old girl, weighing a mere 30 kilograms, was sleeping in a cot, too weak to feed and bathe herself. Elise's fight against HIV became more difficult and painful every day. She died a few days after the pictures were taken, in the loving care of her mother and MSF's medical team. Her mother Agathe wanted MSF to publish her pictures. « *It cannot help Elise, but it may help others in the country* », she said.



Epidemiology

Number of people living with HIV	120,000	[100,000 - 140,000]
Pregnant women living with HIV*	12,221	
Children aged 0 to 14 living with HIV	13,000	[11,000 - 16,000]
Deaths due to AIDS	3,800	[2,500 - 7,200]
New Infections annually	7,200	[5,200 - 9,800]
Adults aged 15 to 49 prevalence rate	1.6%	[1.4% - 1.8%]
HIV prevalence in key populations**:		
Sex workers	16.7%	
Prisoners	9.4%	
MSM	20%	

Source: UNAIDS 2014 data, available from <http://aidsinfo.unaids.org/>

Source *: Draft of national strategic plan for E-MTCT, CNLS-UNICEF, October 2015. Table II.

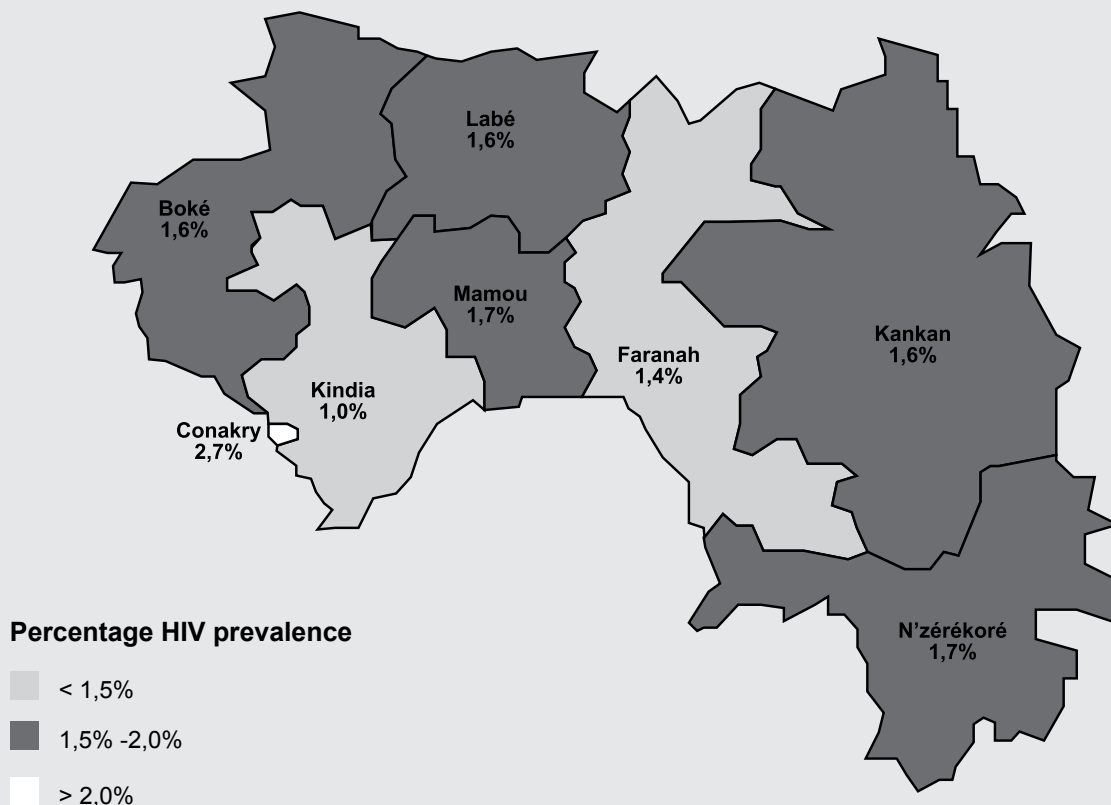
Source **: Spectrum estimates in CCM Concept Note.

Note: Data and information collection methods vary widely according to the source. Caution in their interpretation should therefore be exercised.

GUINEA

AWAITING EXPANDED ACCESS IN A NEGLECTED HIV CRISIS

Figure 1:
Subnational HIV prevalence rates in Guinea



Source: Demographic Health Survey 2012

OVERVIEW

The HIV epidemic in Guinea remains largely overlooked by the rest of the world.

Overall country prevalence of HIV is relatively low, estimated at 1.6% in 2014¹, but with wide variations between urban (2.7%) and rural (1.2%) populations, as well as between women (2.1%) and men (1.2%).² Treatment coverage remains among the lowest in the world, with about one in four people living with HIV (approximately 120,000 in 2014) accessing antiretroviral treatment. In 2014, in MSF-supported prevention to child transmission (PMTCT) services in Conakry, the HIV rate among pregnant women was at 5.4%, considerably higher than the official figures for Conakry (4%) and the national average of 2.6%.³

Although only a handful of international partners support the fight against HIV, the country has made some important strides against the disease and is planning rapid scale-up of ART and PMTCT services. However, fast tracking the HIV response will require removing key barriers to HIV testing and ART, intensified programmatic support, as well as sustained financing at both the national and international level.

The country is emerging from a devastating crisis following the 2014-2015 Ebola outbreak, which represented a serious setback in the fight against HIV. Health organizations that arrived following the epidemic with the intention of rebuilding the existing health system need to include efforts to compensate for the lack of progress in HIV care scale-up during the Ebola epidemic.

¹ UNAIDS 2014 data, available from <http://aidsinfo.unaids.org/>

² Enquête Démographique et Santé (EDS) MICS 2012.

³ Draft of national strategic plan for E-MTCT, CNLS-UNICEF, October 2015 and PNPCSP annual report 2014.

PROGRESS TOWARDS THE 90-90-90

Coverage rates	2012	2014
% people tested last 12 months	5%	
% pregnant women accessing HIV testing for PMTCT *	14%	13.6%
% PLHIV on ART	25%	27%
% HIV+ children on ART **	9.5%	11%
% co-infected patients TB-HIV on ART	27 %	

Source UNAIDS 2013 and 2015, available on <http://aidsinfo.unaids.org/>

Source*: Number of pregnant women tested for HIV on the total of pregnant women expected at population level. The E-MTCT plan gives the figure of 16%; this refers to the number of women tested for HIV during antenatal care.

Source: Draft of national strategic plan for E-MTCT, CNLS-UNICEF, October 2015.

Source**: These figures differ somewhat from the ART coverage for children in annual reports of the PNPCSP: 4.8% in 2012 and 8.5% in 2014.

The 2014-2015 Ebola crisis revealed pre-existing weaknesses of the health system: inadequate numbers of qualified health workers; weak infrastructure and logistics; difficulties in health information, surveillance, governance; and fragile drug supply systems. These factors can also to a large extent explain some of the poor programmatic outcomes of HIV programs.

The negative effects of the Ebola outbreak on the health system created major challenges for the HIV program in 2014 and 2015. Although health facilities never completely closed, utilization rates reduced and people were reluctant to attend health facilities. A drop in general service utilisation was reported (e.g., a 40% decrease in primary health care use⁴).

Voluntary HIV testing services ceased during the outbreak, with the total number of tests in the country dropping from 173,000 in 2013 to 37,000 tests in 2014,⁵ exclusively limited to diagnosis of people already ill. Many patients interrupted their ART for fear of coming to the health facilities or because services were not available due to staff absenteeism or disrupted supply lines. In Conakry, the NGO Solthis reported delays in appointments that created a cumulative loss of up to 42% of patients in care between April and December 2014.⁶ In Macenta, retention in care dropped by 11%; additionally ART initiation has slowed down significantly.^{7, 8} In rural areas it is estimated that even more patients on ART had to interrupt their treatment due to transport problems and more vulnerable supply lines.

⁴ Leuenberger D. et al., Impact of the Ebola epidemic on HIV care in Macenta, Guinée Forestière. CROI conference, 2016. Work by IEDEA West Africa study group. Available from: <http://www.croiconference.org/sessions/impact-ebola-epidemic-hiv-care-macenta-forest-guinea-2014>

⁵ PNPCSP annual report, 2013 et 2014.

⁶ Ndawizine J. et al., Prevention of HIV spread during Ebola crisis, The Lancet Volume 385, April 11, 2015, page 1393.

⁷ Idea study in Macenta showed a drop of 11% in care retention.

⁸ Leuenberger D. et al., Op. Cit.



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TARGET 1: BY 2020 90% OF PLHIV WILL KNOW THEIR STATUS

Coverage of HIV testing was estimated to be 5% in 2012.⁹

Voluntary testing decreased dramatically due to the closure in 2013 of the “Faisons ensemble” project (USAID) which had supported 34 voluntary testing centres across the country. While 221,842 voluntary tests were realised in 2012, of which 44% was done by the “Faisons Ensemble” supported centres, only 145,406 were reported in 2013. The Ebola outbreak led to a further drop in testing: only 37,234 tests were done in 2014.

The majority of HIV tests in the country are currently performed in health centres and are generally used to confirm suspected HIV among people who are already ill. HIV testing is rarely offered at community sites. The Guinean NGO FMG (Fraternité Médicale Guinée) was the only actor performing community based testing for sex workers via their FEVE project (Frontières et Vulnérabilité, 2011 – 2015).



Programs tailored to key populations are included in the country's plans (GF grant) for 2016 and 2017.

Despite an important increase in PMTCT sites (from 5 in 2004 to 262 in 2014), only 16% of pregnant women were tested for HIV in 2014 countrywide.¹⁰ Not all women can access sites for antenatal care offering PMTCT services, but even within the sites that do, only 55% of pregnant women received an HIV-test in 2014.¹¹

The availability of Early Infant Diagnosis (EID) is very limited in Guinea. The country reports that 7% of children born from HIV-positive mothers (434/6157) were tested for HIV before 2 months of age in 2014.¹² Countrywide data collection is a real challenge and these reported tests were all done for children in MSF-supported health facilities. In Guinea, four public laboratory facilities have the equipment to perform viral load (VL) and PCR¹³, but some lack sufficient qualified staff to assure continuous availability of tests. The international NGO DREAM also has a laboratory with VL and PCR equipment. At present a limited number of PCRs are performed, restricted mainly to DREAM and the National Reference Lab, both in Conakry and without organised transport of samples. The national plan aims to equip six additional regional laboratories with VL/PCR.^{14, 15} The Global Fund grant for 2015-2017 foresees specific support for ensuring that over 10,000 children are HIV tested, including a functional system for transporting dried blood spot (DBS) samples.¹⁶

TARGET 2: 90% OF PLHIV ACCESS ART

In 2014, the country's ART coverage was estimated to be 27%.¹⁷

This very low coverage is in part explained by the low level of testing. However, timely initiation of ART is caused by other factors beyond under- and late diagnosis.

Urban-rural inequality plays a major role in unequal health care access: 63% of the population lives in the countryside, while only 17% of medical staff works there.¹⁸ In the health centre of Matam, 25% of patients come from outside of Conakry, despite long travel distances and transport difficulties. The scarcity of health services in rural areas is compounded by a high level of stigma.

⁹ EDS MICS-2012.

¹⁰ Draft of national strategic plan for E-MTCT, CNLS-UNICEF, October 2015

¹¹ PNPCSP, Annual report, 2014

¹² Rapport national de la riposte au VIH/Sida 2014, progrès 2010-2014, CNLS, juin 2015.

¹³ One in Kankan, and three in Conakry: Matam, Donka OPP-ERA, and the National reference laboratory.

¹⁴ National hospital Ignace Deen (Conakry) and five regional hospitals in Kindia, Nzérékoré, Boké, Labé, Faranah

¹⁵ UNICEF & CNLS, Draft of national strategic plan E-MTCT 2015-2017, , October 2015.

¹⁶ Global Fund, Performance framework Guinea, 2015-2017.

¹⁷ UNAIDS 2014 data, available from <http://aidsinfo.unaids.org/>

¹⁸ Ministère de la Santé et de l'Hygiène publique, Analyse de situation des ressources humaines pour la santé, juillet 2011.

Even in the capital city, only 50% (24,284) of the estimated 49,000 PLHIV residing in Conakry, were on ART in 2014.¹⁹

In April 2014 (during the Ebola outbreak), ART initiation in the capital was not possible at certain testing sites and patients were referred to other health facilities that offered treatment. In order to facilitate referral, members of the patient association REGAP+²⁰ accompanied PLHIV to these ART sites and checked if they experienced any difficulties to enrol. After two weeks, patient associations coalition followed up PLHIV by phone to enquire about what happened after referral. Out of a total of 134 PLHIV, 68 (51%) people had started ART (6 died before they could start ART). There was an important variation between health facilities, with some initiating few patients and others many.

In 2015, preliminary reports by a group of local patient associations (Observatoires Communautaires) highlighted the problems of access to treatment for PLHIV in 27 health structures across the country.²¹ They reported that medicines to treat opportunistic infections had been unavailable since 2014 at all of the health facilities surveyed. At the time of the survey, staff reported a stockout of first line ARVs (Efavirenz 600mg) over the preceding two months. Furthermore, CD4 testing (necessary in Guinea to allow initiation and to monitor ARV treatment) was unavailable in 16 out of 27 health facilities surveyed. Reasons for the latter were stockouts of laboratory reagents or machine failures.

With patients initiating ART late, opportunistic infections and complications are frequent. In 2015, in MSF-supported facilities in Conakry, 82% of people testing HIV-positive (915) were already in advanced stages (3 and 4) of the disease. The median CD4 count at ART initiation was 217, a low value which already indicates serious immunity suppression and complications. After hospitalization, 36% of HIV-patients referred by MSF to the capital's central university hospital died. During the first quarter of 2015, MSF had 26 patients with Kaposi sarcoma under treatment.

A short review of 105 newly hospitalised HIV patients in MSF-supported structures during the last semester of 2015 confirmed most inpatients are late presenters. It showed that 34% of them had been tested for HIV less than four weeks prior to hospitalization and 54% of these patients had a CD4 count under 150, indicating severe illness. Among these patients, 34% were diagnosed with TB.

The health system in Guinea functions largely through **out-of-pocket payments**. Patient fees constitute the major part of revenues for health facilities, complementing low state salaries and shortfalls in recurrent costs for public health facilities (salary top-ups, maintenance, functioning costs). The financial contribution from user fees by patients and households is estimated at 62% of all health expenditure.²²

Even though a national decree legislated that ARVs are free of charge, patients often have to pay for other essential care (laboratory tests and essential drugs including medicines for opportunistic infections). Moreover, prolonged stockouts of medicines (such as Cotrimoxazole) for opportunistic infections force patients to buy the drugs in private pharmacies.²³

The systematic underfunding of the public health system, and its dependence on user fees, create several challenges for optimal HIV care including:

- Decreased demand for care: patients that are required to pay for essential care elements are deterred from using services as needed. In certain health facilities, CD4 testing and a standard lab assessment before ART initiation might cost patients between 50,000 and 150,000 Guinean franc (US\$6.4 – 19).²⁴ With 55% of people living below the poverty line²⁵, these financial barriers deter patients from initiating timely treatment and can lead to treatment interruptions.
- Health workers' dependency on patient fees lead to a decrease in the offer of care to PLHIV. Since the main element of HIV care – ART – should be provided free of charge, health workers might feel unmotivated to treat HIV patients. They know they will gain greater revenue from treating a patient with some other illness.
- The risk of sub-optimal quality of care: out-of-pocket fees may lead to incomplete or interrupted treatment for patients; staff may delay ART initiation or encourage over-prescription.

¹⁹ Plan de passage à l'échelle Fonds Mondial (FM).

²⁰ Réseau Guinéen des Associations de Personnes infectées et affectées par le VIH.

²¹ OCASS, Draft report 2015.

²² Etats Généraux de la santé, Financement de la santé, Mars 2014,

²³ OCASS report 2015, *Op. Cit.*

²⁴ MSF and REGAP+, ad hoc survey in Conakry in 2014.

²⁵ The poverty line in Guinea is at 8815 GNF/day = US\$1.12 (Guinée: Stratégie de Réduction de la Pauvreté, FMI, 2013).



Guinea has adopted option B+ -- i.e. all HIV+ women start ART whatever their CD4 count-- for PMTCT.²⁶ The objective of the national strategic plan for elimination of mother to child transmission (E-MTCT) is to establish 875 functional PMTCT sites by the end of 2017. However, important challenges currently curtail the offer of the full package of PMTCT services to all – even to women attending these PMTCT-sites. As explained above, overall only 16% of pregnant women were tested for HIV in 2014. Among 12,221 estimated HIV-positive pregnant women, only 29% received ART.²⁷ In part this can be explained by insufficient availability of both reagents for testing and ARVs. In 2013, only 9% of facilities did not experience any stockouts of testing reagents and 22% did not experience stockouts of ARVs.²⁸ Moreover, the life-long continuation of ART can only be guaranteed when effective referral and inclusion into ART-cohorts is formalised and optimised.

Scale-up of PMTCT programs is all the more important given that 92% of infants born HIV positive do not receive treatment. The latter is driven by a shortfall in PCR- based EID and paediatric ARVs.²⁹

The Global Fund grant for 2015-2017 plans to support 63,178 patients on ART by the end of 2017, which will equate to an ART coverage of 49%. However, considering the resources needed to achieve the specific ART coverage targets for HIV-positive pregnant women (90%) and for TB-HIV co-infected patients (28%), and to ensure links to treatment for people diagnosed through the planned HIV –testing initiative (600,000 tests), a funding shortfall is to be expected. The available funding for new ART initiations is below what is required to ensure coverage of all patients in need of ART.

TARGET 3: BY 2020 90% OF PLHIV ON ART WILL HAVE AN UNDETECTABLE VIRAL LOAD

In Guinea, availability of viral load testing is still limited; without systematic VL testing, assessing progress towards the 90-90-90 target is limited. In 2014, 6,038 VL tests were performed.³⁰ In MSF-supported facilities, 4,644 VL tests were performed in 2015, with 95% of patients showing good control of the virus (VL below 1,000 copies).

The national plan aims to scale up from the current four testing sites (Kankan, Matam, Donka-OPP ERA and National Reference Lab) to include six additional labs in five regional hospitals and in the National Hospital, Ignace Deen.

No official policy exists on how and by whom adherence support for HIV-positive people in care should be offered and, although applied in practice, task-shifting to lay providers workers is not yet formally accepted.

³¹ This gap is partially filled by volunteers from patient associations and small community-based organizations (CBOs). These 'mediateurs' play a critical role in linking PLHIV to HIV testing services, treatment and care (see box). Yet the growing network of patient associations has been weakened by funding constraints and it is difficult to envisage how CBOs will manage to take on board these critical tasks beyond volunteering individual members.

²⁶ The national plan for Elimination of Mother To Child Transmission estimates that 1,381 sites offer antenatal services and the aim is to offer PMTCT services in 875 of these by end 2017 (63%).

²⁷ PNPCSP, Annual report 2014.

²⁸ Draft National strategic plan for E-MTCT 2015-2017, October 2015.

²⁹ PNPCSP report and Spectrum 2013.

³⁰ PNPCSP, Annual report 2014, *Op. Cit.*

³¹ MSF, HIV/TB counselling: Who is doing the job? Time for recognition of lay counsellors, August 2015. Available from: http://www.msf.org/sites/msf.org/files/final_web_counsellor_report_one_page.pdf



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Médiateurs

The involvement of people living with HIV (PLHIV) both in health facilities and in the community is important in the HIV response. These peers are supporting patients to negotiate the different hurdles within the health system they encounter in regard to accessing the necessary services and being retained in care. This role is all the more important given this context where access to ART is difficult. Their counseling role in testing, initiation of ART and adherence is key. They also trace patients as soon as they have missed an appointment. MSF and other NGOs work with the 'médiateurs' or mediators from the community, but they have not been officially recognised by the government so far.

Funding for 41 "médiateurs associatifs" was included in the previous Global Fund grant, but it did not include provisions for training, supervision or functioning costs (such as telephone credit to call patients). Their monthly allowance was equivalent to US\$9.

Under the new grant, 590 additional médiateurs are earmarked for PMTCT. These will be recruited among mothers who have been through the programme some of their training and operational costs will be covered. While training and operational costs (for example mobile telephone and phone credit) will be given to mediators in PMTCT activities, no specific support is foreseen for the 41 initial 'médiateurs associatifs'. The level of their allowance and what it covers varies.

Plans exist to formalise guidance on counselling, including training (covered by the Global Fund grant) in order to help improve patient support. However, formal recognition of mediators, development of a standard task description, and defined measures of support are still needed.

Given the challenge of ensuring uninterrupted HIV treatment during the Ebola outbreak, a pilot scheme was implemented in Conakry during 2014 and 2015 for patients that were on ARVs and stable (i.e. VL<1,000 and at the WHO clinical stage 1 or 2). The frequency of clinic visits were reduced to bi-annual check-ups (hence the common term used of 'R6M'), with a three month ARV drug refills. Patients coming from outside Conakry were given ARVs for six months. Results were encouraging: despite the Ebola epidemic still being in full force, 96% of the patients under the pilot scheme were still on ART six months on. Also the difference in retention in care after 12 months, with 96% versus 86%, was significant (see table). Additionally there was a marked reduction of workload at health facility level.

ART outcomes for patients starting ARVs between June and August 2014

After 12 months	Still active on ARTs	Lost to follow-up (LTFU)	Died	Transferred
Patients on R6M (n= 630)	603 95.7%	20 (3.2%)	5 (0.8%)	2 (0.3%)
Patients not on R6M (n= 467)	403 86.3%	57 (12.2%)	4 (0.9%)	3 (0.6%)

The government is now interested in rolling out these less frequent clinic visits and refills for longer periods to improve retention in care and adherence, and reduce unnecessary workload for health workers. The experience in Guinea confirms the findings from studies elsewhere³² and is in line with the WHO recommendation to reduce the frequency of clinic visits and refills for stable patients on ART. This approach is also helps decrease treatment interruptions in a crisis situation – including conflict and displacement scenarios - where access to health facilities is compromised.

³² Bemelmans M. et al., Community-supported models of care for people on HIV treatment in sub-Saharan Africa. *Trop Med Int Health*. 2014 Aug;19(8):968-77. doi: 10.1111/tmi.12332. Available from: <http://samumf.org/download/bemelmans-comm-supported-models-2014-tmih-pdf>

FUNDING

The country estimates that funds of US\$95.6 million are needed for the HIV response in 2016, of which only US\$31.6 million is guaranteed at the moment: US\$28.1 million by the Global Fund and US\$3.5 million by the Guinean government.³³

Although the proportion of the national budget allocated to health overall has decreased in the last few years (from 3.5% in 2010 to 1.75% in 2013), in absolute figures the government's contribution to HIV has increased and was budgeted at USD 3.2 million in 2014; domestic funding represented 22% of all HIV spending in 2014.^{34, 35}

There is little interest from international donors to support HIV-related initiatives in Guinea. In 2015, MSF was the second largest provider of ARVs in the country, after the Global Fund. This is quite exceptional for MSF, but is in response to the serious lack of alternative funding sources aside from the Global Fund, particularly in relation to ART initiation.

USAID financially supported HIV prevention and testing services until September 2013 and then phased out its support, resulting in the scale down of these interventions. The new Global Fund grant is expected to compensate for this gap by including several key interventions such as HIV testing services, focus on key populations and support to CBOs and local associations.

In the absence of PEPFAR, Guinea relies heavily on the Global Fund (GF). In 2011 the Global Fund funded up to 50% of the country's ARV drugs. The remaining gap was only partially filled by agencies such as MSF, GIZ and DREAM, putting constraints on ART initiation scale up capacity. In 2012 for instance, the ongoing Global Fund grant foresaw 110 initiations per month in the entire country of Guinea, which was well below the needs, as illustrated by the 145 patients that MSF initiated as a monthly average in Conakry alone.

As the main funder of the HIV program in Guinea, the Global Fund's approach will be critical for the further evolution of the country's epidemic. Under the New Funding Model of the Global Fund, a total of USD 61.8 million has been approved for HIV for the period October 2015 to December 2017.^{36, 37} The new grant foresees providing 67% of the ARV drugs needed in Guinea, for treatment of 63,178 patients by 2017.³⁸ This however falls quite short of the estimated 120,000 PLHIV that already today need ARVs. Without any alternative funding sources, how can the fast-track plan be effectively supported? How will this gap impact the planned inclusion of additional patients?

If Guinea is to continue increasing ART initiation for PLHIV, more diversified funding combined with technical and programmatic support is needed. Both traditional health donors present in the country and those new actors that arrived after the Ebola outbreak need to contribute to fast tracking of the HIV response. With their renewed commitment, crucial strategies can be implemented to step up the pace.



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³³ HIV operational coordination meeting presentation, February 4th, 2016.

³⁴ CNLS, Rapport national de la riposte au VIH/Sida 2014, progrès 2010-2014, juin 2015

³⁵ It is not clear if the reported contribution to HIV from domestic source takes into account expenditures by households, such as through out-of-pocket expenses for care and treatment.

³⁶ <http://www.theglobalfund.org/en/fundingdecisions/>

³⁷ US\$ 62.7 million (program budget) and US\$60 million in the final grant agreement.

³⁸ Cadre de performance soumis au FM.

RECOMMENDATIONS

In the wake of the recent Ebola crisis, an ambitious catch-up plan is needed to fast track the roll out of HIV services in Guinea. Concerted action from all relevant health stakeholders has the potential to close the treatment gap that these last few years have widened.

- All partners should join in an effort to accelerate the current HIV response and improve operational strategies, based on critical analysis of the current bottlenecks to accessing of treatment.
 - Increased attention post-Ebola provides Guinea with an opportunity to appeal to additional international support to improve health. The national authorities responsible for the HIV response should define a strategy that attracts the input of some of these actors.
- Large scale-up of HIV testing services is urgently needed, with both systematic promotion of provider-initiated testing (antenatal care, inpatients, TB wards, malnourished children, etc.) and community-based testing involving lay counsellors, especially for key populations. In the wake of the post-Ebola era, a large public push for HIV testing is necessary, starting in the capital Conakry.
- The Government has to ensure that all essential elements of HIV services – prevention, treatment and care – are effectively provided free-of-charge, including consultation fees, all necessary laboratory exams and drugs for opportunistic infections.
 - Currently providing care for HIV patients free-of-charge is not compensated by subsidies from other sources. This leads to a paradox, where lack of health staff motivation hampers adequate care of HIV patients. Alternative targeted subsidy mechanisms –such as patient voucher systems– could solve this problem.
- Patient support and simplified treatment models could dramatically improve quality and continuity of HIV care:
 - Lay counsellors and ‘médiateurs’ who do testing, initiation and adherence support, should be recognised as key in improved linkage to and retention into care, with fair remuneration included. In particular, the approach whereby ‘médiateurs’ call patients immediately after a missed appointment should be expanded and sustained. This system seems more cost-effective than active searching of patients already lost to follow-up for some time.
 - Patient education and counselling protocols tailored to the needs of patients have to be elaborated and need to be integrated in the national regulatory system.
 - The experience of wider spacing between clinical appointments and organising ARV drug refills for longer periods of time should be rolled out for all stable patients.
 - Additionally, these patients could benefit from peer support at the community level, through patient clubs for example.
- In the urban context of Conakry, further decentralisation of treatment sites within existing health facilities may not be optimal to significantly accelerate the pace of ART initiation. Given the relatively low prevalence and easy geographic access, a few well-functioning “ART centres”, with experienced, motivated and well-trained staff could be useful to assure adequate care for PLHIV in Conakry. Close supervision, assured supply lines for drugs and tests and specific patient (peer) support in these centres can combine quality of care and patient volume. Once initiated and stable, patients can be referred to 6-monthly refills in the community or health centres, with clinical and viral load monitoring once a year.
- Improved monitoring and reactive adjustments:
 - A simple, harmonised patient monitoring system is needed to improve monitoring of patient outcomes, including tracking of the mother-infant pair in the PMTCT program from antenatal care until end of breastfeeding.
 - Under the current initiative of “Observatoires Communautaires” (patient associations supported by national and regional civil society organisations), PLHIV check and report on problems of service provision at peripheral level. This allows for fast mitigation of responses and better accountability. Wider implementation of this monitoring system could boost quality and access to HIV care.
 - Additionally, monitoring of the performance of the supply chain, alert and reporting mechanisms, combined with quick responses to signaled problems should be put in place. Buffer stocks and emergency orders of medical supplies can make the system more robust and nimble. The use of systems of improved access to pharmaceuticals and services (SIAPS)³⁹ for improved management of ARV and other HIV commodities and technical assistance by international partners is recommended for improved management of ART and other HIV commodities.
- In a country where stigma is still widespread, peer support is key in improving access to and quality of health services provided. PLHIV are central to advocacy for a stronger and more effective HIV response. Their voices are important to raising public awareness and political will to tackle HIV. As such, international support to civil society, and in particular patient associations, is crucial.

³⁹ USAID financed development of the OSPSIDA commodity management tool for West Africa. Various agencies in Guinea were trained on its use. See link: <https://ospsida.org/index.php/en/>

CONCLUSION

Guinea has not been a priority for international funders and organisations, and in particular HIV and PLHIV have been largely neglected. Nevertheless, together with the few partners involved in the HIV/AIDS response, the country has made progress towards curbing the epidemic. The Ebola outbreak has impacted Guinea's ability to provide health services, further weakening its health indicators.

Faced with the challenge of needing to fast track the HIV response and fill the existing treatment gaps, we must do much more to reach the targets of 90-90-90 by 2020. The current situation presents a 'now or never' opportunity to mobilise an ambitious step-up plan, directing available resources into effective strategies and adapted models of care that will benefit PLHIV and prevent further spread of infection.

While only a handful of health agencies were actively involved with Guinea before 2014, this has changed dramatically since the Ebola outbreak hit the country. This increased international attention is an opportunity for the country not only to boost again its health services, but also to attract and tap into support for expansion of HIV treatment. Without better investment from major donors and actors, fast tracking of the HIV response will not be possible.

MSF has been working in Guinea since 1984, providing HIV and TB services since the start of ARV treatment in 2003. Currently, in collaboration with the Ministry of Health, MSF provides support to 7,639 HIV patients (24% of the national ART cohort). It offers diagnosis, treatment and adherence support through a decentralised approach in six health centres across the capital city, as well as at an outpatient clinic in Matam district. MSF offers viral load testing for patients in the facilities it supports. MSF also supports hospital care for severely ill patients and treatment for Opportunistic Infections (OI) such as Kaposi Sarcoma. MSF partners with patient associations that provide peer support, monitor health outputs through the 'Observatoires' and advocate for scale up of ART access.

Aboubacar – “HIV is in my blood, the fight is in my soul”

I will never forget this dreadful day of February 9th 2008. At that time, I kept getting sick over and over again and I had no idea what was gnawing at me. The doctor proposed the HIV test, but it took some convincing for me to accept to take it – I thought that HIV only affected prostitutes. When I received this piece of paper saying “HIV positive”, I crumbled on the floor, crying, thinking my life was over. But the doctor reassured me and started me on ARVs.

Once I felt better I transferred to Kankan to finish my university studies, previously interrupted because of my health problems. When I came out of my first consultation at the hospital I bumped into a childhood friend who was working there. The doctor I had just consulted with came out of his consultation room, interrupted us and told my friend “don't talk to this man. He's HIV positive”. This devastated me so much that I stopped my treatment – better die than face this scorn.

I became so sick that I had to stop my studies and come back to Conakry in my parent's home. I was doing nothing but lie down, alone in the house, waiting to die. I'm the poster child of AIDS-related illnesses: name any opportunistic disease, I got it at one moment or another!

But one day I heard on the radio a woman who was living with HIV and who worked for MSF. She was

speaking openly about her status and the need to keep on treatment. This was like an electric shock for me: this woman saved my life! I got in touch with her, she encouraged me to seek treatment again and I decided to do for others what she did for me. Since then I've been an activist with a patient organization from the Regap+ coalition.

Two years ago, I was giving a speech for a support group of HIV-positive young people and I noticed this beautiful girl in the room. I soon proposed, we're now married and are trying to have a child.

Apart from one aunt who raised her, nobody in my wife's family knows her status, even though both her parents probably died of AIDS-related illnesses. She was diagnosed when she was 12 years old. I'm encouraging her to come out in the open and speak out about her status, like me, so that we can help other Guineans who live hidden, in fear. We'll see.

Today, I have only one fear: that despite my treatment, I fall sick again. It already happened in 2012: I was hospitalised for 18 days in a critical state; that's when I heard that I was on treatment failure and I had to switch to second line ARVs. I can't get sick anymore, really, I can't. I've been telling everybody I know that HIV is not a death sentence, so if I fall ill again all my efforts will go to waste. My wife and I have to stay healthy, for us, for our future children, and for all other Guineans living with HIV.



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