

WESTERN AND CENTRAL AFRICA

No time to lose:

overcoming barriers to acceleration of
HIV treatment



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The West and Central Africa region

Despite having ambitious global goals to be reached by 2020, known as the “90-90-90” target¹, the Western and Central Africa (WCA) region is significantly lagging behind on each level of the HIV treatment cascade.

In 2015 only 36% of people living with HIV (PLHIVs) knew their HIV status in WCA, compared to 62% in Eastern and Southern Africa (ESA)², and 60% globally. Antiretroviral therapy (ART) coverage was estimated at 28%, compared to 54% in ESA³, leaving 4.7 million PLWHIVs without treatment. ART coverage was even lower for children, with 20% in WCA compared to 45% in ESA. Out of the 25 countries in WCA, only three have ART coverage higher than 50%⁴: Burkina Faso (55%), Burundi (54%) and Gabon (58%).

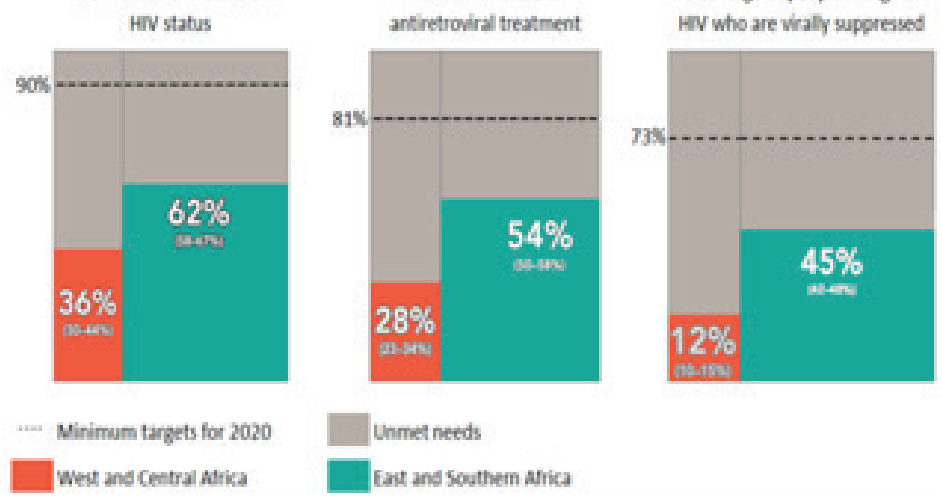
In 2015 the number of new HIV infections (estimated at 410,000) was higher than the number of patients who had recently started receiving ART treatment (estimated at 240,200)⁵.

In a time when viral load measurement is the primary tool used to monitor patients on ART, its availability remains very limited in WCA countries. In 2015 only 12% of patients receiving ART had a test confirming they had an

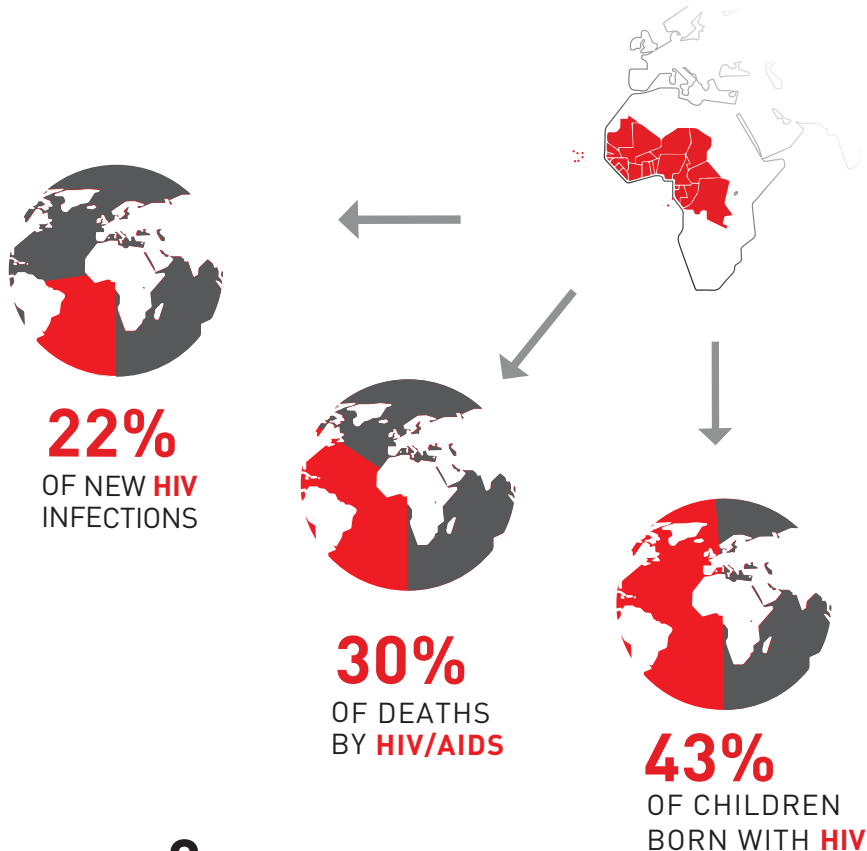
undetectable viral load, compared to 45% in ESA⁶. Yet this region is home to 18% of the total number of people living with HIV (PLHIV), with 22% of new infections in the overall population and 43% of new infections among children worldwide⁷. In 2015, the number of deaths linked to HIV in WCA contributed to an estimated 30% of all HIV-related deaths worldwide⁸.

Comparing the HIV treatment cascade in WCA and ESA⁹ shows that WCA is lagging behind that of ESA, and that a large part of unmet needs are located in WCA.

Treatment cascade in WCA and ESA (Source: UNAIDS 2015)



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Policy, systems and financial barriers are key obstacles in the region

• Over-medicalisation and centralisation of services

Task shifting of HIV testing, initiation of antiretroviral therapy (ART), drug dispensing and counselling from doctors to nurses and lay workers proved highly effective in scaling up access to ART in the ESA region. These approaches remain to be adopted and implemented at scale in the WCA region.

The 2015 WHO guidelines for HIV testing, which 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 services¹⁰, have hardly been implemented in WCA. HIV testing at facility level is not systematically done and the majority of HIV tests currently performed in health centers are generally used to confirm suspected HIV among people who are already ill.

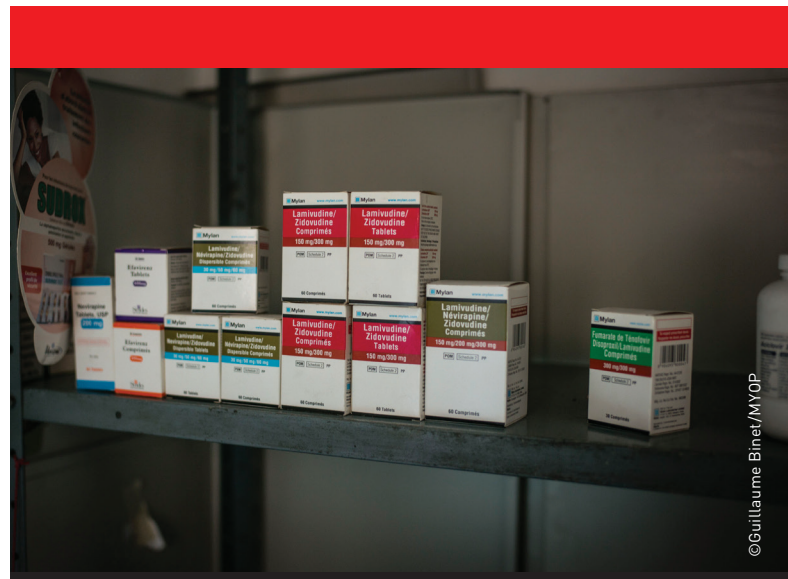
Patients are most often initiated on ARVs by doctors who are mostly located in capitals and large cities. For example, in Bangui, CAR, only a limited number

of doctors are authorised to initiate patients on ARTs, despite the fact that national legislation states since 2014 that nurses can initiate patients on ART.

In the ESA region, putting non-professional counsellors in charge of testing, counselling and adherence support activities (such as patient education, treatment literacy and active contact tracing of patients who are lost to follow-up) constitutes an essential step to improve treatment initiation and retention in care. Task shifting policies and differentiated models of care still need to be rolled out in WCA. Effective implementation of task shifting to nurses and counsellors could lead to a rapid expansion of HIV treatment services, a reduction in the number of patients who are lost to follow-up and a general improvement in treatment adherence¹¹ in health facilities and within the community.

• Weak, dysfunctional supply chains

In WCA, inefficient supply chains provide significant barriers for patients to access ARV medications. MSF has regularly witnessed inadequate distribution systems of medical commodities to health facilities or communities resulting in regular stock-outs. Last mile delivery up to health facilities is often lacking. Supply systems often suffer from stock visibility and as such are neither flexible nor reactive enough to respond to the real demand and to prevent stock-outs. Reasons for this include inadequate quantification of needs and poor monitoring of supply levels at central, peripheral and health facilities level. In the Democratic Republic of Congo (DRC), there have been regularly documented ARV stock-outs since 2011¹².



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In 2016 in Kinshasa, DRC, a survey conducted by MSF, the Ministry of Health and two civil society organisations showed that during the last 3 months 50% of visited facilities had a stock-out of at least one ARV, 45% for at least one paediatric ARV and 38% for at least one adult ARV. The average ARV stock-outs lasted two months for 70% of the surveyed health facilities and for one third of the stock outs, patients left the health facilities without treatment. One in two patients receiving second-line ARVs in the visited healthcare facilities had been affected by stock-outs. This survey also demonstrated that 13% of establishments had experienced a stock-out of HIV tests. All these commodities were in fact available at the central or provincial warehouse, and in 44% of cases, available in the health zone¹⁵.

In Liberia, there was a paediatric ART stock-out, while in Sierra Leone, PLHIV faced stock outs for adult first and second-line ARVs as well as paediatric ARVs¹³.

Shortages and stock-outs at the health facility level are a significant bottleneck for patients' access to treatment and retention to care. Not being able to access medication can result in viral resistance and have a negative impact on survival rates.

• Insurmountable financial barriers

PLHIV face enormous financial barriers to accessing HIV care in the public sector. While HIV tests and ARV drugs are by law free of charge, significant direct payments are still required from patients for drugs against opportunistic infections (OIs), consultation fees, lab tests (pre-therapeutic assessment, measurement of viral load) and hospital expenses.

In 2016 MSF conducted a qualitative study at the centre hospitalier de Kabinda in Kinshasa, DRC, among patients arriving with advanced HIV, caregivers and health personnel to understand the factors behind delays in seeking care for some PLHIVs and those influencing treatment adherence. One of the main reasons given were payments for care and drugs¹⁶. In Bangui, CAR, a viral load test can cost up to (the equivalent of) 50 euro for patients on ART. The same financial barriers prevent treatment continuity for PLHIV already on treatment, whose health declines after

ART treatment is interrupted or halted. In particular patients at an advanced stage of the disease can't afford the necessary specialised care. In hospitals in Kinshasa, the average hospitalisation cost for a PLHIV can go from USD 160 to USD 280¹⁷, which is unaffordable for most patients.

In several countries in the WCA region, patients are seen as a source of income for health facilities and their staff, who receive very low state wages. "They operate like shops," says a clinician about health facilities in Kinshasa¹⁸. Health personnel are reluctant to care for PLHIV, who should receive care free of charge. The search for revenue from patients also means reluctance to implement rational practices to reduce unnecessary consultations and the frequency of ARV renewals. Facilitation of follow-up and ART renewal outside of health facilities is also perceived as a loss of income to health structures and providers.

• Strong Stigma against PLHIV

High levels of stigma and lack of information about HIV in the WCA region have a negative impact on care for PLHIV at all levels of the HIV treatment cascade. In the above mentioned Kinshasa study stigma and discrimination were considered to

be major hurdles to treatment adherence, and prevented patients from seeking care when they become ill. People remain fearful of testing for HIV or seeking care unless they are very ill¹⁹.



- **Funding falls short of acceleration plans for most countries in the region**

In 2015, overall international funding for HIV decreased by USD 1 billion compared to 2014²⁰.

For international donors, priority is given to countries where incidence rates and absolute figures are considered a bigger contribution to the worldwide HIV burden, including ESA countries and a limited number of WCA countries, such as Nigeria, Cameroon, DRC and Ivory Coast.

In the WCA region, the Global Fund remains the main donor and often sole supplier of ARVs, with PEPFAR present in only 6 out of 25 countries.

However for the majority of WCA countries, the Global Fund's allocation for the 2018 – 2020 period will either remain the same or decrease, leaving little room to accelerate bART provision and improve quality of care. For example in CAR, where the number of patients on ARV treatment doubled between 2013 and 2016 reaching an ART coverage of 24% despite enormous constraints, the Global Fund's future allocation will be insufficient to ensure treatment continuity for these patients

- **Limited support to civil society**

The decrease in international funding specifically affects civil society organisations, including patient associations, which play an essential role in the rollout of HIV-related services, the fight against stigma and in advocacy. Further MSF is witnessing reluctance from health authorities, governments

or provide care to HIV positive people awaiting treatment, estimated to be 29,000 people at the end of 2016²¹.

Donors count on the increased participation of governments who are being asked to do more with less. However, in the current economic context this is unfeasible for most countries in the WCA region. 15 out of the 25 countries are low-income countries, according to the World Bank's 2016 classification²² and several countries classified as 'middle income' face insufficient health budgets. Pressure to increase domestic funding could directly increase the burden of medical costs for patients. In these countries, the majority of the population live below the poverty line and health care costs remain a major barrier to accessing care and a risk for further impoverishment. In DRC in 2013 - 2014, 44% of all HIV expenditure came from household revenues, mostly through direct patient payments²³.

and international implementing partners to involve civil society and patients associations in service provision, testing, treatment and adherence support operations, as well HIV care monitoring activities.

Consequences for PLHIV

The consequences of these barriers to testing, treatment and access to quality care are catastrophic for PLHIV in this region. In 2015, 30% of deaths linked to HIV globally were located in WCA. Children are the most affected, with four out of ten HIV-related child deaths occurring in this region.

In Conakry, within the MSF-supported care unit for patients with advanced HIV/AIDS at Donka University Hospital, the mortality rate is

extremely high: 43% of inpatients admitted died between December 2016 and May 2017. Patients arrive very ill, severely immunosuppressed with deadly opportunistic infections (OIs)²⁴. At the CHK in Kinshasa, 31% of cases die within the first 48 hours²⁵. In Conakry and Kinshasa, the majority of hospitalised patients with advanced HIV, respectively 96% and 71%, have been on ART and their treatment has either failed or has been interrupted.



Call to remove barriers to access to HIV testing and treatment: implement key strategies to ensure an acceleration of HIV response in WCA

The following actions and strategies are essential to remove the barriers faced by PLWHIV and ensure a successful response to HIV in WCA. The commitment of governments as well as technical and financial partners is vital to overcome these obstacles.

• Implement WHO's "Treat all" recommendation in the region's 25 countries

Since 2015, the WHO has recommended that all people diagnosed with HIV start ART immediately, regardless of their CD4 count. This approach, called "Treat all", presents several advantages: early ART improves treatment results, reduces

HIV transmission and mortality rates²⁶. But so far, only seven out of 25 countries have implemented this recommendation, compared to a majority of ESA countries where "Treat all" is now national policy²⁷.

• Implement a "free of charge" policy for all elements of HIV and TB care for PLHIV

Patient fees for PLHIV should be removed in order to rapidly comply with the "Treat all" recommendation before people become ill, and to keep patients on treatment in good health for their entire life. It is therefore necessary to implement a targeted subsidy to replace patients' payments. One solution could be to use vouchers, in order to ensure free of charge treatments and services for patients; this method would prevent caregivers' disinterest in non-paying PLWHIV and empower PLWHIV in claiming their right to free treatment.

Drugs for treating Opportunistic Infections (OIs) should also be free of charge. Specific funds should be allocated to cover both out- and in-patient costs for patients with advanced HIV, including diagnostics, treatment and care.

Finally, the role of and support to civil society will be essential in monitoring if policies of free access to care are applied, for instance relying on the experience of community observatories, as now in DRC, Guinea and Cameroon.



• Adopt and implement differentiated ART access models as national policy

The WHO recommends implementation of differentiated models of care for easier access to ART and longer ARV prescriptions for stable patients²⁸. These models include three-to-six-month ART prescriptions, distribution of ART through patients groups and the spacing of clinic visits to save time and transport costs for PLHIV. These models of care also help to reduce the health staff workload, who can then focus on ART initiation, patients experiencing difficulties with treatment adherence, and complex cases. Differentiated care helps the health system refocus its resources towards those who need them most²⁹.

These models have been successfully implemented by MSF and are now being adopted by the Ministry of Health as national policy in DRC and Guinea. These models have significantly enhanced patient

retention, with respectively 91% and 95.8% retention reported after 24 months of treatment. In Zemio, CAR, a similar mechanism is currently being tested with positive preliminary results.

For countries in the WCA region, MSF recommends national governments adopt national policies that support decentralisation and task shifting to nurses and counsellors. Task shifting should not only allow nurses to prescribe ART and initiate patients, but also authorise lay staff to do testing and counselling activities, ensure implementation of various activities regarding patient retention and treatment adherence support, such as therapeutic education, tracing of patients lost to follow-up, both in health facilities and in the community³⁰.

• Improve in-country supply chains

Implementing an effective and efficient supply chain requires avoiding low stock levels and stock-outs of drugs and other medical commodities. This includes a monitoring system and a quick response system when difficulties arise. Renewed interest and attention must be dedicated to

WCA countries' supply chains in order to ensure continuous supply of ART up to health facility level and to allow stable patients to receive ART for a period of three to six months, preferably at the community level.

At country level, it is essential to implement:

- A monitoring and assessment system based on indicators that measure low levels and stock-outs in health facilities and the community;
- A strong and detailed budget for all inputs, including operational costs for the delivery of all commodities up to the level of ART distribution points;
- A limitation on the number of intermediary storage sites;
- An emergency response system to counter or mitigate threats of stock-outs in health facilities;
- Continuous investments in an independent monitoring system to ensure quality control within civil society, such as a "community observatory";
- A clear emergency preparedness plan (contingency plan) to ensure continuity in ART and treatments during crises;
- A flexible budget, ability to include funding for buffer stocks and fast funding mobilisation during periods of stock strains (linked to molecule changes or prescription durations for patients).

At regional and international level:

- Implement a system of alerts and immediate response at regional and international level in order to prevent stock-outs ;
- Implement a regional and international coordination platform and share successful supply chain management experiences;
- Intensify efforts to increase the flexibility and responsiveness of supply systems by making them less complex administratively and more efficient.

- **Actively involve civil society and PLHIV associations**

Accelerating HIV care will not be possible without involving civil society. 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.

These groups play a key role in HIV-related service provisions, such as testing, counselling and adherence support, both in health facilities and the community. Further, they are essential

as independent agents to monitor quality and accessibility of services. The community observatories implemented in Burkina Faso, Cameroon and DRC are perfect examples of this role of independent monitoring bodies. These entities, whose contribution to the HIV response is paramount, need stable funding and technical support in order to scale up their contribution to the acceleration plans.

- **Combine national commitments and international funding:**

Given the willingness of WCA governments to triple access to ART by 2020³¹, it is necessary to assure sufficient funding to support this acceleration. For countries in the region, it is absolutely impossible to rely only on domestic funding for scaling up treatment. International donors'

financial contributions must be consistent with their political commitments and support all WCA countries through adequate technical support and financial means.

Conclusion

The ambitious 90-90-90 worldwide target will not be reached if countries in the WCA region remain on the side lines without catching up.

It is essential to remove the main barriers faced by PLHIV and support a large-scale response based on quality care with the aim of reaching more people. Scaling up effective and quality HIV treatment to those who need it will only be possible thanks to effective task shifting to nurses and trained non-

professional agents, direct involvement of civil society associations in HIV service provision and the swift extension of differentiated care models. This large-scale response will rely on strong supply systems, based on independent stock-out monitoring managed by civil society and patient associations, and quick response mechanisms to counter input stock-outs in health facilities.



More information on experiences in HIV treatment by MSF

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

Towards an increased, more effective care for PLWHIV in West and Central Africa: dissemination of three novel approaches piloted by MSF, 2016

Available at: <http://samumsf.org/blog/portfolio-item/podi-toolkit/>
Press release, HIV response in West and Central Africa

will not succeed if key barriers remain unaddressed, 3 July 2017.

Available at: <https://www.msf.org.za/stories-news/press-releases/msf-hiv-response-will-not-succeed-west-and-central-africa-if-key>

Out of Focus: how millions of people in West and Central Africa are being left out of the global HIV response

Download full report: www.doctorswithoutborders.org/article/out-focus

Notes

¹ The 90-90-90 target aims for 90% of all people living with HIV to know their HIV status, for 90% of all people with diagnosed HIV infection to receive sustained antiretroviral therapy, and for 90% of all people receiving antiretroviral therapy to have viral suppression.

² WHO – UNAIDS peer review workshop, WHO presentation, 2-4 May 2017

³ 2015 UNAIDS data, available on <http://aidsinfo.unaids.org/>

⁴ 2015 UNAIDS data, available on <http://aidsinfo.unaids.org/>

⁵ 2015 UNAIDS data, available on <http://aidsinfo.unaids.org/>

⁶ WHO – UNAIDS peer review workshop, WHO presentation, 2-4 May 2017

⁷ 2015 UNAIDS data, available on <http://aidsinfo.unaids.org/>

⁸ 330,000 deaths in WCA out of 1,100,000 deaths globally

⁹ WHO – UNAIDS peer review workshop, WHO presentation, 2-4 May 2017

¹⁰ WHO, Guidelines – HIV testing services; WHO, Geneva, 2015

¹¹ MSF, HIV/TB counselling: Who is doing the job? Time for recognition of lay counsellors, August 2015. Available at: http://www.msf.org/sites/msf.org/files/final_web_counsellor_report._one_page.pdf

¹² <http://www.lasemaineafricaine.net/index.php/national/14477-lutte-contre-le-sida-le-congo-appelle-a-en-finir-avec-le-phenomene-de-rupture-de-stocks-d-a-r-v>

¹³ WHO and UNAIDS, Réunion JURTA sur la situation des stocks dans les pays d'Afrique de l'Ouest et du centre, en rupture et en pré-rupture (JURTA meeting on stocks in WCA countries (pre-stock-outs and stock-outs)), 23 June 2017

¹⁴ MSF, PNLS, RNOAC, UCOP +, PNAM, État des lieux de la disponibilité des intrants essentiels pour la lutte contre le sida (State of play regarding the availability of essential commodities against AIDS), Kinshasa, 2017. This study covers 73% of PLHIVs on ART in Kinshasa, 94 health units, 33 health area central offices and 2 warehouses.

¹⁵ MSF, idem, page 9

¹⁶ MSF, Emilie Venables, "Even if she's really sick at home, she will pretend that everything is fine". Why do people living with HIV in Kinshasa, DRC, delay seeking healthcare and treatment? May 2017, page 11

¹⁷ MSF, AEDES, Quentin Baglione, Étude de coûts: hospitalisation des PVVIH à Kinshasa (Cost study: Hospitalisation of PLWHIVs in Kinshasa), DRC, April 2017, page 7

¹⁸ MSF, Emilie Venables, "Even if she's really sick at home, she will pretend that everything is fine". Why do people living with HIV in Kinshasa, DRC, delay seeking healthcare and treatment? May 2017, page 4

¹⁹ MSF, Emilie Venables, "Even if she's really sick at home, she will pretend that everything is fine". Why do people living with HIV in Kinshasa, DRC, delay seeking healthcare and treatment? May 2017, page 9

²⁰ Kaiser Family Foundation. Financing the Response to HIV in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2015. July 2016. [Online]. Available from: <http://files.kff.org/attachment/Financing-the-Response-to-HIV-in-Low-and-Middle-Income-Countries-International-Assistance-from-Donor-Governments-in-2015>

²¹ CAR, Funding request, Global Fund, 15 February 2017 version, page 7

²² <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519>

²³ PNMLS, UNAIDS and PEPFAR, National Aids spending accounts (REDES) for 2013 and 2014, 22nd of November 2015

²⁴ MSF Guinea, data for December 2016 – May 2017

²⁵ MSF, Patients en stade avancé : les négligés de l'infection au VIH. Une prise en charge adaptée et gratuite est leur seule chance de survie (Patients with advanced HIV are the most neglected in the HIV response. Appropriate and free care is their only chance of survival, Kinshasa, DRC, July 2017, page 15

²⁶ 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.

²⁷ WHO Presentation/ Paris Meeting with UNAIDS: Senegal, DRC, Cameroon, Nigeria, Tchad, Ghana, Burundi

²⁸ For more information about differentiated HIV care models, go to <http://www.differentiatedcare.org/>

²⁹ IAS, Differentiated care for HIV: A decision framework for antiretroviral therapy delivery, page IV, www.differentiatedcare.org

³⁰ Médecins Sans Frontières, Vers une prise en charge plus efficace et accrue des PVVIH dans la région d'Afrique occidentale et centrale : partage de trois approches novatrices pilotées par MSF (Towards better and increased care of PLWHIVs in Western and Central Africa: Presentation of three innovative approaches managed by MSF), 2016

³¹ http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2017/july/20170704_africanunion

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