OUT OF FOCUS

" What we see today in our projects in West and Central Africa sometimes reminds me of South Africa in 1999, a time before antiretroviral drugs were widely available and when HIV positive people were typically brought to us on the verge of death.

A decade and a half have since past, but too many of the patients we care for in the Democratic Republic of Congo, Guinea or the Central African Republic still show advanced stages of AIDS which have become relatively rare in South Africa since the mid-2000's. In West and Central Africa AIDS is far from over, and will not be unless drastic action is taken to increase access for all to ART, and before people are so ill "

Dr Eric Goemaere, MSF HIV/TB referent.

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

April 2016

MEDECINS SANS FRONTIERES

1. FAST TRACKING TO "90-90-90" FOR WEST AND CENTRAL AFRICA

The widely embraced UNAIDS "90-90-90" targets aim at having 90% of all people living with HIV knowing their status, 90% of them initiated on antiretroviral treatment and 90% of those on optimal quality treatment as measured by an undetectable viral load. According to the UN agency[1], achieving those goals by 2020 would curb the HIV epidemic, meaning that new cases of AIDS will have all but disappeared by 2030. In contrast, failing to reach these targets by the deadline would allow the epidemic to rebound, representing an even more serious threat.

International health funding for HIV/AIDS and antiretroviral treatment (ART) has been focusing on high-burden countries in Sub-Saharan Africa and on HIV 'hotspots' , i.e. places and people with high occurrence of HIV transmission. This trend is increasingly pronounced in the context of reaching the 90-90-90 targets, particularly as main global actors such as UNAIDS, PEPFAR, the Global Fund and others aim to sharpen their focus on those 'hot spots' that will benefit from the full package of 'Fast track' interventions.[2]

Meanwhile, countries who contribute less to global indicators, for example because of relatively small population size or because their populations living with HIV are dispersed across the country instead of being concentrated in 'hot spots', may fall off international priority agendas, even if they already lag significantly behind in terms of ART coverage. This is the case for most countries in the region classified by the UN as West and Central Africa[3].

An excessively narrow focus on so-called priority areas risks an unfair rationing of lifesaving interventions away from regions with low ART coverage, leaving them with a serious treatment gap. The Fast Track strategy should aim at treating all people living with HIV and especially those already left behind. A targeted acceleration effort for access to early ART in countries lagging behind, such as in West and Central Africa, is long overdue.

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1 http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf

2 UNAIDS Fast Track strategy is available here: http://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf

3 *West and Central Africa is composed of 25 countries: Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Congo, Cote d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, São Tomé and Príncipe, Senegal, Sierra Leone, Togo*

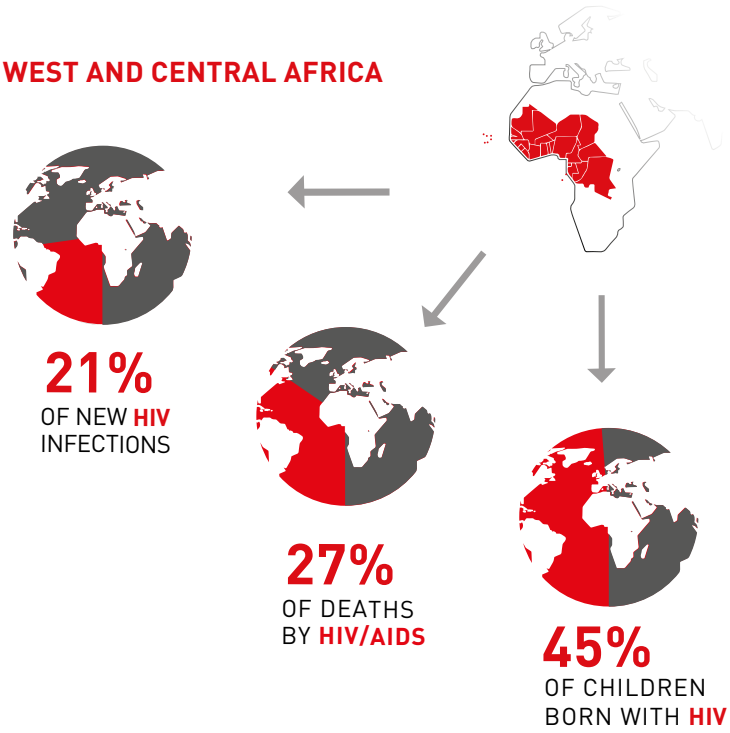
2. LOWER HIV PREVALENCE BUT LARGE NUMBERS OF PEOPLE LIVING WITH HIV STILL WAITING FOR ART

Logic suggests that health systems in countries with lower prevalence, and therefore fewer people living with HIV, should be better able to cope with the burden of offering lifelong treatment. But this logic does not hold true in the majority of countries in West and Central Africa. As a hidden epidemic, HIV is considered neither a health nor a political priority. Subsequently, investments against the disease remain very low.

While countries faced with an overwhelming HIV burden (mostly in Eastern and Southern Africa) have risen to the challenge by making major changes to their health services, countries in West and Central Africa have had less incentive to adapt their service delivery models, and received less support to do so. Many also struggle with weak health systems and competing health priorities. As a result, antiretroviral coverage is much lower in countries with a lower prevalence[4].

4 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



Antiretroviral coverage in West and Central Africa is amongst the lowest in the world, with three in four people not accessing AR. This amounts to five million people with unmet need, or a third of the overall "90-90-90" target of initiating an additional 15 million people worldwide on ART (effectively doubling the number of HIV+ individuals currently in care).

Although the 25 countries comprising West and Central Africa represent only 6% of the world's population, they make up 17.9% of all people living with HIV. HIV's toll in terms of disease and deaths in the region is disproportionate to its relatively low average prevalence of 2.3%. In 2014, 330.000 people died of HIV-related causes, or 27% of all AIDS deaths worldwide. Moreover, low antiretroviral coverage means that transmission of the virus remains unchecked: one in five new infections worldwide and 45% of all children born with HIV globally occur in West and Central Africa.

The number of people starting ARV there 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 West and Central Africa while an estimated 420,000 new infections occurred. Considering the key role that timely treatment plays in reducing not only deaths and suffering but also the number of new infections, **a failure to fast track the HIV response in West and Central Africa will jeopardize the overall goal of getting the worldwide epidemic under control.**

"There was a time when I totally lost hope. Everyone abandoned me: my family, my four brothers, my husband who sent my children away from me, to the village, and threw me out to marry another woman when I started to lose weight. While I was ill, people came to my house and took everything, believing I was going to die. It was so traumatic that I had a relapse. I spent all my money in health centres and hospitals. When all my cash ran out, the centre threw me out. They said "Go home, you're going to die". Thankfully 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"

37 year old patient, Kinshasa, DRC

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3. OBSTACLE COURSE TO ACCESS HIV TREATMENT

Many direct or indirect constraints contribute to the substantial treatment gap in West and Central Africa: limited political will, weak health systems and little leverage to improve access to quality treatment.

> *"When I came out of my first consultation at the hospital I bumped into a childhood friend. My doctor came out of his room and told him "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 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! Thankfully one day I heard an activist talking openly about being HIV positive on the radio. She inspired me to go back to treatment and become an activist. Today, I have only one fear: that despite my treatment, I fall sick again. 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"*
>
> Patient, Conakry, Guinea

A. The barrier of stigma

Because of the unavailability of treatment, HIV in West and Central Africa becomes the death sentence it is wrongly presumed to be, leading to very high fear and stigma. Stigma acts as a barrier that hampers the development of an active civil society activism, a factor essential to increase patients' demand for care.

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 Matam clinic come from rural areas outside the capital, saying they lack access to services closer to home that they trust.

B. Low levels of HIV testing & ARV initiation

The entry door to diagnosis and treatment remains extremely narrow in West and Central Africa.

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 West and Central Africa. At health facility level, HIV testing services are rarely offered systematically and various barriers hinder their uptake, such as stock-outs of tests, patient fees, a lack of counselling support and reluctance on the part of clinical staff to propose testing.

Even patients with a long medical history and obvious clinical signs have never been tested for HIV. In 2012 in the DRC, when MSF teams offered HIV test and counselling to inpatients in the medical wards of three Kinshasa hospitals, 90% said they had never been offered an HIV test before.

WHO guidelines for immediate ART initiation after HIV diagnosis are of limited use if testing does not occur until the patient is already gravely ill, severely immunosuppressed, and suffering opportunistic infections as is presently the case. This contributes to preventable human suffering, overburdens health services and has a serious economic and social cost. For example, in the MSF-supported HIV-hospital in Kinshasa, one in four HIV inpatients arrives too ill to be saved. In MSF-supported hospitals in the Central African Republic where overall prevalence is just below 5%, 25-29% of hospitalised patients suffer HIV-related illness, while an estimated 84% of all intra-hospital deaths are due to HIV.

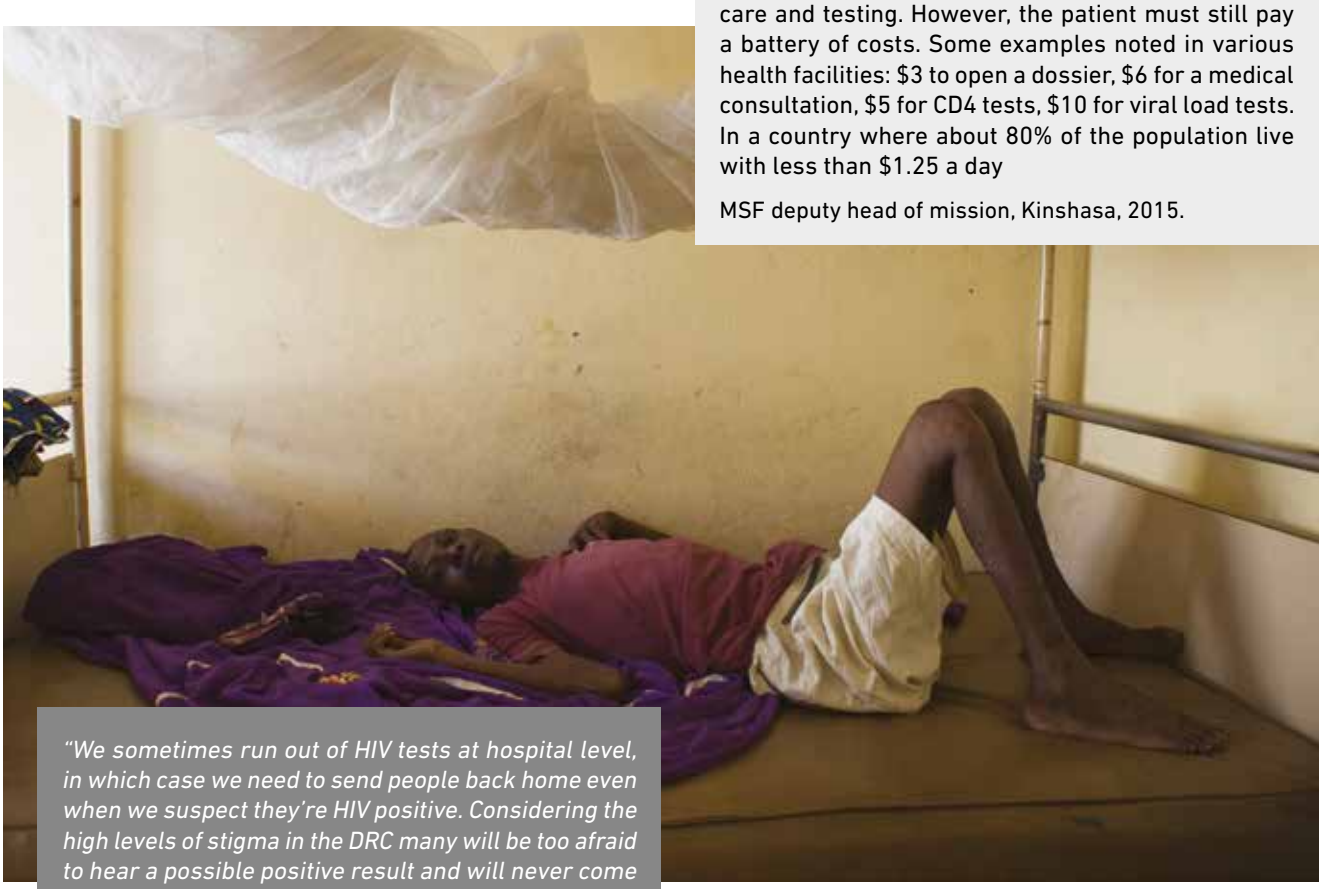
C. Weak health systems

As most health systems in West and Central Africa are weak, health service provision remains inequitable, often detached from the urgent needs of people and in particular the most vulnerable. This makes both initiation on ART and retention in care a challenge.

- Patients are often excluded from healthcare because of unaffordable fees. Even if ARVs are mostly free, additional fees are charged for consultations, HIV tests, laboratory exams and the prescription of drugs for opportunistic infections. Meanwhile under-resourced health facilities dependent on patient fees may be reluctant to implement 'free ART' schemes, limiting offer of HIV care.
- Weak supply systems result in frequent stock-outs of drugs, equipment and other commodities. In a 2015 survey carried out in Kinshasa, DRC, 77% of health facilities visited reported one or more stock-outs of at least one ARV during the previous three months, resulting in 68% of HIV patients being sent away without the necessary medication[5]. An estimated 4,000 patients were not tested because of stock-outs of HIV-tests.
- Proven strategies, such as task shifting, decentralization, community involvement or the implementation of simplified protocols and drug regimen, are still lagging behind.

In the DRC a 2008 law ensures free access to HIV care and testing. However, the patient must still pay a battery of costs. Some examples noted in various health facilities: $3 to open a dossier, $6 for a medical consultation, $5 for CD4 tests, $10 for viral load tests. In a country where about 80% of the population live with less than $1.25 a day

MSF deputy head of mission, Kinshasa, 2015.



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"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 the 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"

Director of nursing in public hospital, Kinshasa.

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

D. The needs of people living with HIV neglected during crises

Several countries in the region are repeatedly exposed to crises such as conflict or epidemics, Ebola for example, which disrupt provision of HIV care. While crisis and instability are not the sole cause of low ART coverage, they act as additional obstacles magnifying already existing challenges. The current humanitarian crisis response fails to give sufficient attention to HIV or provide measures to mitigate the vulnerable status of people living with HIV. While the need for continued ART for people already on treatment is recognised, continued initiation is rare. However, we cannot afford to drop the pace of initiation, as this will widen the treatment gap.

Most ART programmes lack either a comprehensive contingency plan for emergency scenarios, or key elements thereof: 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. Equally lacking is a systematic catch-up plan after such crisis situations that can, at least in part,

> *"We lost many patients during the crisis. Nowadays most patients who come back are very sick, sometimes critically, and we've noticed an increase of AIDS-related hospital admissions this year: 70% of patients in our medical ward are there for AIDS-related diseases."*
> HIV/TB doctor for MSF in Carnot hospital, Bangui, CAR

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4. 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

Albert is the 55-year-old president of an MSF peer support group in Bukavu, South Kivu, DRC. He was diagnosed with HIV in 2008 after falling gravely ill. 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.

5. AN URGENT CALL TO ACTION

Global goals to curb the HIV epidemic and end AIDS by 2030 cannot be met unless the HIV response is also fast-tracked to benefit people and communities in West and Central Africa. In the optimistic scenario where the Fast Track strategy successfully reaches its 90-90-90 goal by 2020, the victories achieved will bypass those countries already left behind by the AIDS revolution. The current treatment gap in West and Central Africa might further and disproportionally grow.

In West and Central Africa, like in other places in the world, the deadly cycle of HIV/AIDS can be broken through mobilization of political will and dedicated efforts. Lessons learnt on HIV treatment scale-up elsewhere could be game changers for people living with HIV in West and Central Africa. However, certain policies and approaches currently being applied will need modification, due to the scope and spread of the epidemic, stigma against people living with HIV and specific weaknesses in the existing health systems. Experience has shown which strategies work and should be applied in priority. But for this to happen, a sense of urgency is required to overcome obstacles in policy and politics.

People's right to lifesaving ARVs should not be based on who they are, where they live or the specific characteristics of the HIV epidemic they face. If the global community is serious in its goal of defeating AIDS, additional funding should be mobilised towards these priority strategies. While it is essential that governments of countries affected increase their domestic resources towards health and HIV, this will not suffice. International partners must ensure consistent financial commitment to scale up ART and prevention, especially as the world moves to roll out the 'treatment for all' approach.

This is why MSF is calling for an ambitious catch-up plan for countries with low ART coverage, such as most of those in West and Central Africa. The people left behind by the HIV revolution over the past decade must not be forgotten once again. Crucially, the next four years may be their last chance to benefit from what the world has learned from the successful mobilization against HIV. We should, and can, care for the most vulnerable and neglected, for their sake and for the sake of curbing the epidemic.

For more information, read the MSF report 'Out of Focus - *How millions of people in West and Central Africa are being left out of the global HIV response*' www.doctorswithoutborders.org/our-work/publications

The report aims to highlight the shortfalls in policy and practices for people living with HIV in West and Central Africa. It points to key obstacles to boosting ART coverage in West and Central Africa, focusing on contexts where MSF is involved in the HIV response and brings together the experience of MSF teams, including data from local pilot projects, small-scale patient data collection, patient surveys and other programmatic data; it describes pilot projects with alternative approaches, both in West and Central Africa 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.

The international humanitarian organization Médecins Sans Frontières/MSF has been working on HIV/AIDS since the early 1990's. It currently supports treatment for over 200,000 patients in 19 countries, primarily in Africa. This includes HIV programs and activities in West and Central Africa: DRC, Guinea, CAR, Chad, Niger and Mali as well as other countries with low ART coverage such as South Sudan, Yemen and Myanmar.

ELISE AND PHILO MÈNE :
TWO FACES OF THE FIGHT AGAINST HIV IN THE DRC

Philomène embodies "what should be": in a world with wide access to antiretroviral treatment, people living with HIV can lead healthy, productive and fulfilling lives.

Elise though represents the stark reality of "what is": for the large majority of people living with HIV in West and Central Africa, HIV remains a death sentence.

As the world renews its pledges to quickly accelerate the fight against HIV, now is the time to decide which fate should befall the 6.6 million people living with the virus in West and Central Africa.

Business as usual condemns them to follow Elise's tragic fate;

Urgent action could allow them to emulate Philomène's.

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 welcomed 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, helping her countrymen and women to better understand HIV and fight stigma.

ELISE
THE FAILURES OF THE SYSTEM

As her mother Agathe was never screened for HIV and therefore 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. Elise developed resistance and had to be switched to the more difficult to tolerate second line ARV drugs, all the more difficult because the unavailability of pediatric drugs meant that 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 », she said.

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For more information on MSF and HIV/AIDS see also:
www.samumsf.org

Find the full report on:
www.doctorswithoutborders.org/our-work/publications