WEST & CENTRAL AFRICA HIV CATCH-UP

WHO in an era of transformation

World Health Organization
African Region

Contents

Abbreviations

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
AU	African Union
CAR	Central African Republic
CDC	Centers for Disease Control and Prevention
CSDTs	Tuberculosis diagnostic and treatment centres
DRC	Democratic Republic of the Congo
DSD	differentiated service delivery
EMRs	Electronic Medical Records
ESA	Eastern and Southern Africa
FOSA	Formation Sanitaire
GHSS	global health sector strategy
GIZ	Gesellschaft für Internationale Zusammenarbeit
GNP+	Global Network of People living with HIV
HIV	human immunodeficiency virus
ICW	International Coalition of Women living with HIV
IFRC	International Federation of the Red Cross
ILO	International Labour Organization
IN	United Nations
JURTA	Joint United Nations Regional Team on HIV/AIDS
MSF	Médecins Sans Frontières
MTCT	mother-to-child transmission
NACA/SACA	National Agency for the Control of AIDS/ State Agencies for the Control of AIDS
NAIIS 2018	National AIDS Incidence and Impact Survey
NASCP/ SASCP	National AIDS and STDs Control Programme / State AIDS and STI control programme
NDR	National Data Repository
NISRN	National Integrated Sample Referral Network
NTPP	National Treatment and PMTCT17 programme
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child HIV transmission
PODIs	Points communautaires de distribution de TAR
SDGs	Sustainable Development Goals
SMoH	State Ministries of Health
Solthis	Solidarité Thérapeutique et Initiatives pour la Santé
TB	tuberculosis
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	the UN Development Programme
UNFPA	UN Population Fund
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
WAHO	West African Health Organization
WCA	Western and Central Africa
WCO	WHO country office
WFP	World Food Programme
WHO	World Health Organization

Overview

The HIV treatment catch-up and fast-track plan has achieved its target of seeing the West and Central African region (WCA) catch up with the Eastern and Southern African region's (ESA) antiretroviral coverage rate of 78% in 2021, albeit later than the 2020 target time frame. A 33% improvement was achieved in WCA, against 21% in ESA, between 2015–2020. WCA achieved a significant 42% increase, compared to ESA's 23%, between 2015 and 2021, to see WCA draw level with ESA at 78%. In the Democratic Republic of the Congo (DRC) alone, progress of up to 47% was observed between 2015 and 2020, for example. In addition, 1.6 million more People Living with HIV (PLHIV) were enrolled on antiretroviral treatment (ART) between 2015 and 2020.

Executive Summary

The Transformation Agenda (TA) ushered in an ambitious reform process intended to transform the World Health Organization (WHO) into an organization that is proactive, results-driven, accountable and which meets stakeholder expectations, towards transforming and improving public health services in the African Region. It aimed to achieve a WHO that is pro-results, which optimally and creatively targets technical work as well as make operations more responsive, with greater effectiveness in both communications and partnerships. The Africa Region has been the epicentre of the human immunodeficiency virus (HIV) epidemic and it's one of the leading causes of disease and death on the continent. The WHO, with partners, has worked tirelessly for many years to control the threat and reduce the negative impact of the disease.

Since the early 2000s, significant progress has been made in the global fight against the scourge of HIV. However, the WCA subregion was falling concerningly behind ESA on several key indicators of progress. In 2016, the WHO joined UNAIDS, UNICEF and other partners in a call for a strong and urgent response to support WCA countries to develop catch-up plans to triple and fast-track ART coverage, to enable the region to catch up with ESA by the end of 2020. Implementation of a widespread test-and-treat strategy, coupled with the scale-up of differentiated service delivery (DSD) and mobilization of requisite funding, accelerated WCA's progress towards this goal.

Despite barriers and challenges that include fragile health systems, competing health priorities, and the high resource demands of the COVID-19 pandemic, significant progress was made. This is evidenced by increases in ART coverage, higher numbers of people living with HIV being aware of their status, and a reduction in the number of new HIV infections and acquired immunodeficiency syndrome (AIDS) related deaths.

The catch-up and fast-track plan achieved its target of seeing WCA (78%) catch up to ESA (78%) in 2021, albeit later than the initial 2020 target. This marked a significant 42% increase in ART coverage in WCA, against ESA's 23%, between 2015 and 2021, irrespective of increases in testing and diagnosis. A 33% improvement was achieved in WCA, against 21% in ESA, between 2015 and 2020. Significant progress of up to 59%, 47% and 46% was observed respectively in countries like the Democratic Republic of the Congo (DRC), Sao Tome and Principe and Nigeria between 2015 and 2021. Up to 1.6 million more PLHIV enrolled on ART during the period. Historically, this is the highest recorded number.

Cabo Verde (99%), Sao Tome & Principe (95%) and Burundi (91%) had all achieved or surpassed 90% for ART coverage by 2020, with Nigeria achieving 90% by 2021. Ten additional countries achieved coverage of between 69% and 77%, with the DRC (47%), Sao Tome & Principe (44%), Burundi (41%), Cameroon (37%), and Cote d'Ivoire (37%) recording the biggest improvements by the end of 2020. The least improvements were seen in the Republic of the Congo (2%), Gabon (7%), Mauritania (9%), The Gambia (10%), and Guinea (15%). Among children (0-14 years) living with HIV on treatment, an improvement of only 13% was recorded between 2015 and 2020 in WCA, which was significantly lower than for adults. For elimination of mother-to-child transmission (MTCT), progress was poorer, with a -6% decrease in WCA compared to a mere 5% in ESA between 2015 and 2020.

Executive Summary

More people living with HIV (PLHIV) now know their status, with a 22% improvement between 2015 and 2020, up from 50% to 72%. Also, a rising number of PLHIV are achieving viral suppression; up from 25% in 2015, to 47% in 2020. The number of new HIV infections and AIDS-related deaths has been declining consistently. Cote d'Ivoire, the DRC, and Nigeria are notable examples of countries that effectively implemented several interventions and made significant progress during the period, the details of which are highlighted in this document.

Key factors which contributed to the success of the catch-up initiative included strong national ownership, high-level advocacy and political commitment, with countries drafting plans tailored to their own contexts and needs. The second key factor was the strong and effective partnerships between UN agencies including the WHO, UNAIDS and UNICEF, with the WHO leading, to achieve the 90-90-90 targets. Other agencies such as the World Food Programme (WFP), the UN Development Programme (UNDP), the UN Educational, Scientific and Cultural Organization (UNESCO), along with community-based, civil society and international organizations like the West African Health Organization (WAHO), Médecins Sans Frontières (MSF), the International Federation of the Red Cross (IFRC), the (US) President's Emergency Plan for AIDS Relief (PEPFAR), the US Agency for International Development (USAID) and the US Centers for Disease Control and Prevention (CDC), all collaborated in the joint programme. Third was the adoption and extensive and effective implementation by all the 25 countries in West and Central Africa of the WHO's 2016 HIV guidelines, including the test-and-treat-all policy, an intervention strategy promoting early and regular HIV testing and immediate treatment for everyone diagnosed with the disease. Fourthly, the scale-up of differentiated service delivery (DSD), which tailored HIV care services to individual patient needs and preferences, based on their specific contexts and circumstances, proved crucial. This increased access, improved quality of

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care, and optimised the use of health care resources. Several countries have implemented the Differentiated Service Delivery model, leading to significant increases in the number of people who know their HIV status and improved antiretroviral coverage between 2015 and 2021, notably in the DRC (46% and 59%) and Nigeria (41% and 46%), among others. These key factors, among others, were the fundamental drivers of the recorded successes of the catch-up initiative.

It should be noted, however, that various factors have negatively influenced the achievement of results in some countries, especially those that didn't do well. These include inadequate political commitment in a few countries, health system weaknesses, security and health crises like COVID-19 and Ebola, to name a few.

Lessons learned included the benefit of utilizing innovative approaches to increase access and coverage, such as the differentiated service delivery model. Others are the significant difference made by the WHO's strong leadership and technical assistance, coupled with effective collaboration and partnerships across the board, a dogged commitment to achieve the catch-up plan goals, along with the use of accurate data to drive strategies. This was especially the case in Nigeria, where analysis of existing data led to the acquisition of new information which provided evidence to resolve the HIV prevalence problem, and helped to reset the baseline.

Going forward, innovative ways of achieving set goals need to be promoted and tailored to target countries' needs. Key groups that are not currently well-served, such as children and areas like the elimination of mother-to-child transmission, need special effort and targeting to raise both ART coverage rates and increase viral load suppression. Continued sharing of lessons and good practices should be promoted. Finally, strong advocacy for the removal of punitive laws and policies is required, along with the need to consider the humanitarian contexts of countries when crafting intervention strategies to improve success rates.

1 Introduction

1. Introduction

Controlling HIV in a transformation era

In 2015, an ambitious reform plan called the Transformation Agenda (TA) was initiated with the intention of changing the World Health Organization (WHO) into an organization that is proactive, results-driven, accountable, and which meets stakeholder expectations, with a view to transforming and improving the delivery of public health services in the Africa Region. The reform process was designed to ensure that the organization's activities align with regional needs, priorities and commitments, to meet stakeholder expectations. It was aimed at making WHO in the region more "proactive, results-oriented, accountable and appropriately resourced to deliver on its mandate". The reform was to be achieved via four key focus areas: pro-results values, smart technical focus, responsive strategic operations, and effective communications and partnerships.[1]

One of the technical programmatic areas on which the WHO has worked on for several years, has been the control of the human immunodeficiency virus (HIV). This was in response to the region becoming the epicentre of the HIV epidemic, with the virus one of the leading causes of disease and death in the region. The work of the HIV programme has been consistent with the key smart technical focus of the Transformation Agenda in the WHO's battle against this leading cause of morbidity and mortality, across all ages, in the region. The programme has utilized appropriate strategies and policies to prevent, interrupt and accelerate the reversal of the HIV epidemic in the region. Others included the delivery of high-quality treatment, coupled with care and support, even in difficult and resource-limited settings including those that are crises prone.

1 The Transformation Agenda of the World Health Organization Secretariat in the African Region 2015 - 2020 [Online] accessed 3rd June 2022. Available at: https://www.afro.who.int/regional-director/transformation-agenda

1. Introduction

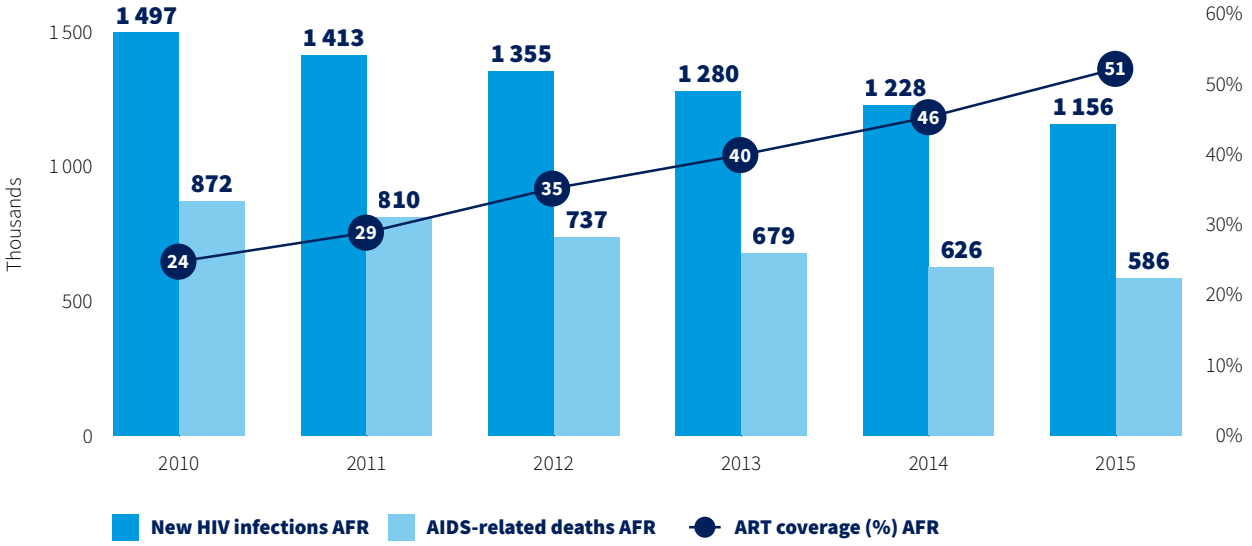
Over the years, the WHO's HIV programme has supported Member States, enabling the provision of services and helping to implement proven, evidence-based interventions, such as the use of condoms, HIV testing and counselling. Other interventions have also included antiretroviral therapy (ART), prevention and treatment of sexually-transmitted infections (STIs), and advocacy, to name a few. These effective interventions have succeeded in turning the tide on the HIV epidemic in the region, especially in the Eastern and Southern Africa (ESA) subregion and, more recently, the Western and Central Africa (WCA) subregion.

Considerable global strides but lack of progress in WCA

Since the early 2000s, significant improvement has been made in the global fight against the scourge of HIV. This improvement was facilitated in several regions of the world by a combination of factors, such as increased funding, strong political commitment and scientific breakthroughs. This has significantly altered the trajectory of the HIV epidemic, accelerating the amount of progress achieved in the Africa Region (Figure 1.1), and driven primarily by improvements in ESA. ART coverage continued to increase between 2010 and 2015, resulting in PLHIV living longer, and a consequent reduction in the number of deaths associated with the disease. New HIV infections also decreased steadily over the period.

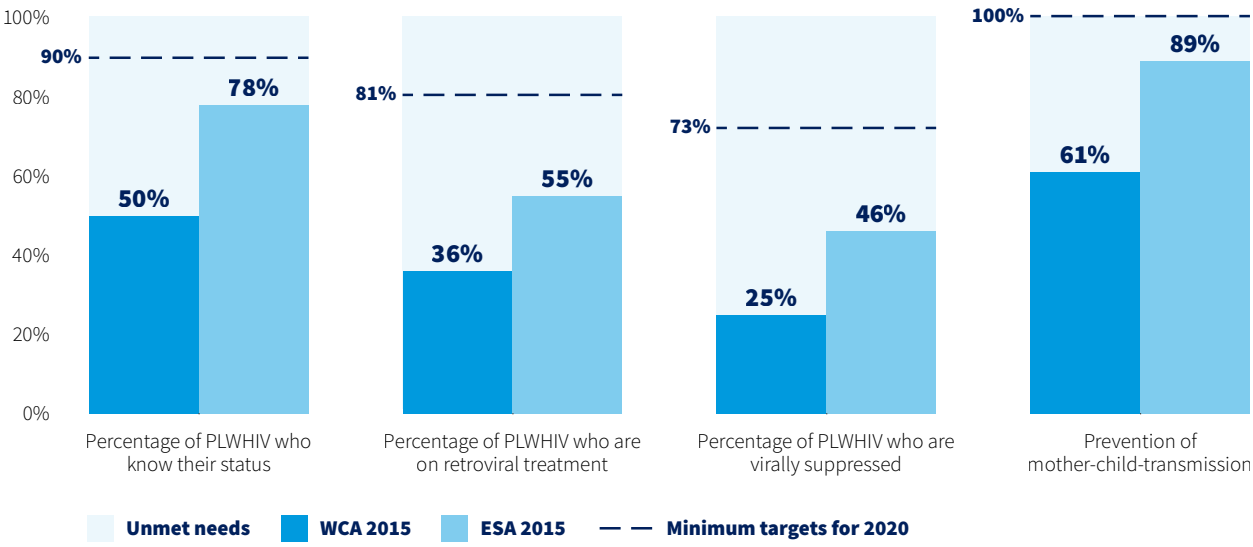
1. Introduction

Figure 1.1 Progress in the African Region, with a reduction in new HIV infections and AIDS-related deaths, coupled with a consistent increase in ART coverage between 2010–2015



However, despite these positive indications in Africa, the WCA subregion made little headway and fell critically behind ESA in several key indicators of progress (Figure 2). This inadequate progress was evident in the percentage of PLHIV who knew their status, those who were on ARTs, and who had achieved viral suppression. Figure 2 also shows that ESA was doing much better in respect of all these three vital indicators by the end of 2015 – at 78%, 55% and 46% respectively, compared to 50%, 36% and 25% for WCA. The same trend was observed for prevention of mother-to-child HIV transmission (PMTCT), with 89% achieved in ESA against 61% in WCA. These differences were attributed to ESA being at the centre of the global HIV epidemic, and the recipient of major international attention for several years.[2] WCA, meanwhile, had received lower levels of attention, financing and other resources. WCA governments also showed delayed political commitment to the response against HIV in the subregion.

Figure 1.2. Demonstrates key HIV indicators in ESA versus WCA in 2015 and the minimum targets for 2020



2 Advancing the HIV response in the Western and Central Africa in the era of Universal Health Coverage, 2019

1. Introduction

Although HIV disease trends were declining in WCA, the rate of decrease was too slow. This was the consequence of neglect, delayed political commitment, and failure to adapt innovative techniques as had been implemented in ESA. This resulted in unnecessary increases in the burden of HIV disease in WCA, but also preventable AIDS-related deaths in the subregion. As a result of these outcomes, it became imperative to address these issues with a view to reducing disparities in HIV control between WCA and ESA. Hence, the decision by the WHO, working with partners in the Africa Region, to support the WCA HIV catch-up initiative.

2 The WCA HIV catch-up plan

2. The WCA HIV catch-up plan

At the 2016 United Nations (UN) high-level meeting on ending HIV as a public health threat by 2030, held in New York. The WHO joined the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF) and other partners to call for a strong and urgent response to support WCA countries to fast-track and triple ART coverage by the end of 2020.This was titled the Western and Central Africa Catch-up Plan.

It was described as both a political tool and an agreement amongst WCA countries, with international support for strategies, policies and plans to rapidly address not only bottlenecks, but also to step up national HIV responses to control the disease. The aim was to change the trajectory of HIV by accelerating treatment coverage, to meet the Fast-Track 90-90-90 targets by 2020.[3] Twenty-five countries incorporated the WCA plan into their national catch-up plans to describe how they intended to unlock bottlenecks, and achieve the ambitious target of tripling ART coverage by 2019. These plans were expected to supplement existing national plans and strategies, increase ART coverage to reduce the burden of disease and save lives, while also increasing testing and positively impacting AIDS-related deaths and new HIV infection rates in WCA.

3 West & Central Africa Catchup Plans: Putting HIV Treatment on the Fast-track by 2018

2. The WCA HIV catch-up plan

HIV targets

The target of the WCA catch-up plan was to triple ART coverage. The entire premise was based on the 2016–2020 HIV/AIDS framework for action in the Africa Region, the primary aim of which was to end HIV as a public health threat by 2030. However, key objectives were to guide Member States in the region to execute the 2016–2021 global health sector strategy (GHSS) on HIV/AIDS. This was to contribute to achieving the 2030 Sustainable Development Goals (SDGs), Universal Health Coverage (UHC) and to help articulate priority actions necessary to achieve the global HIV targets. The ultimate goal was to achieve zero new HIV infections, AIDS-related deaths or HIV-related discrimination in a region, so that PLHIV could live long and healthy lives.[4]

Furthermore, the ambitious global HIV goals set by UNAIDS in 2015 and named 90-90-90, was to be achieved by 2020. The aim was to ensure that 90% of people living with HIV knew their status, 90% of people diagnosed with HIV were receiving ART, and 90% of those on treatment had achieved viral load suppression. Another vital objective was for all countries to have integrated essential HIV services into national health financing arrangements. It is worth noting that, at the time of documenting the progress of the WCA catch-up plan, the global health sector strategies (GHSS) on HIV, viral hepatitis and STIs have been updated for 2022–2030.[5]

Lastly, the 90-90-90 goal also served as the basis for minimum treatment targets for the WCA catch-up and fast-track plan for 2016–2020. These are 90-81-83 for PLHIV who, respectively, know their status, are on ART, and have achieved viral load suppression, with the overarching focus of tripling ART coverage in WCA countries.

4 HIV/AIDS: Framework for actions in the WHO African Region, 2016-2020 [Online] accessed 10th August 2022. Available at: https://apps.who.int/iris/bitstream/handle/10665/259638/EndAIDS-eng.pdf;sequence=1

5 Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030 [Online] Accessed 30th August 2022. Available at: file:///C:/Users/kulausah/Downloads/9789240053779-eng.pdf

2. The WCA HIV catch-up plan

The HIV catch-up approach

A dual-track approach was adopted, as agreed by countries and partners in the WCA catch-up pact. The first track commenced with 11[6] countries in late 2016; eight[7] from West Africa and three[8] from Central Africa. Countries were chosen for a variety of reasons, and included four high-burden countries (Cameroon, Côte d'Ivoire, DRC and Nigeria). In 2015, these countries accounted for 66% of all new HIV infections, and 63% of AIDS-related deaths in WCA, with ART coverage at an average 34%. Inherent in the plan was an expectation that any significant improvement in these high-burden countries would positively impact overall progress in the entire WCA subregion.

Furthermore, Guinea, Liberia and Sierra Leone, which were all impacted by the 2014 Ebola outbreaks, were considered to have weak health systems and required urgent support to fast-track HIV interventions. The Central African Republic (CAR) was a post-conflict country with fragile communities, presenting fertile conditions for rapid HIV spread. The second track comprised the remaining 14 countries in the WCA subregion. It began with country consultations, identification of bottlenecks and consideration of potential solutions, and interrogation of lessons learned from previous implementation efforts. This evolved into a catch-up plan for each of the remaining countries, and culminated in their implementation in Benin, Burkina Faso, Chad, Equatorial Guinea, Gabon and Senegal, among others.

WCA catch-up plan partnership

The WCA HIV catch-up plan was designed to involve all partners in the WCA HIV response, with the WHO and other UN co-sponsors and partners collaborating in a joint programme. It aimed to be more collaborative and intended to foster integration and effective partnerships. The WHO was designated to lead the partnership, with a view to achieving the 90-90-90 targets. The organization was supported by the partnership known as the Joint United Nations Regional Team on HIV/AIDS (JURTA), which consists principally of UN-related agencies like UNAIDS, UNICEF, the World Food Programme (WFP), the UN Development Programme (UNDP), the UN Population Fund (UNFPA), the UN Educational, Scientific and Cultural Organization (UNESCO), and the International Labour Organization (ILO). Other non-UN partners engaged in the HIV response in the subregion are the West African Health Organization (WAHO), Médecins Sans Frontières (MSF), Solidarité Thérapeutique et Initiatives pour la Santé (Solthis), the International Federation of the Red Cross (IFRC), Expertise France, the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) including the Global Fund, and the (US) President's Emergency Plan for AIDS Relief (PEPFAR) as well as the US Agency for International Development (USAID) and the US Centers for Disease Control and Prevention (CDC).

6 Benin, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ghana, Guinea, Liberia, Nigeria, Sierra Leone
7 Benin, Burkina Faso, Cote d'Ivoire, Ghana, Guinea, Liberia, Nigeria, Sierra Leone
8 Cameroon, Chad, DRC

2. The WCA HIV catch-up plan

The WHO's contribution to implementing the WCA catch-up plan

Following the commencement of implementation of the initial catch-up plans in late 2016, there was strong advocacy for all the remaining WCA countries to join. As a result, eight additional countries developed catch-up plans to accelerate and scale up HIV ART delivery. These plans were funded via existing country grants and additional funding from partners, as well as renewed domestic funding commitments in participating countries to accelerate implementation. The WHO's contributions to the implementation of catch-up plans in several countries included provision of funding, scientific leadership and technical support, among other assistance.

The WHO Regional Director for Africa and the UNAIDS Executive Director co-sponsored a high-level dialogue in Geneva on 22 May 2017, on the side-lines of the World Health Assembly. The meeting brought together Ministers of Health from Benin, Burkina Faso, Cameroon, Chad, Cote d'Ivoire, DRC, Gabon, Guinea, Liberia, Nigeria and Sierra Leone, with Botswana and South Africa sharing their experiences. The meeting advocated for stronger leadership, ownership and accountability in the provision of HIV services in the WCA subregion. The ministers also committed to change the narrative, agreed on country-specific key actions, and coordinated priority directions.

It was during this meeting that the Regional Director assured Ministers that the WHO, in collaboration with partners, would provide the necessary support to implement country catch-up plans, towards tripling ART coverage in the region by the end of 2020. The partners also pledged their commitment at country and regional level during the event. They included the Global Network of People living with HIV (GNP+), Stop TB Partnership, MSF, the International Coalition of Women living with HIV (ICW), the Global Fund, Coalition+, UNITAID, the International Federation of the Red Cross (IFRC), the Africa Union (AU), and France.

The WHO developed an emergency plan to support implementation of the HIV catch-up plans in countries, with the organization's leadership in the Africa Region, through the Regional Director, pledging to provide support to accelerate the execution of significant activities contained in these plans. In consonance with this commitment, an initial amount of US$ 480 995 was allocated to 10 WHO Country Offices in 2017 as

2. The WCA HIV catch-up plan

catalytic financing. This was to support the health sector and help facilitate achievement of countries' HIV targets. In addition to financial support, the WHO provided human resources in the form of technical experts who had worked with countries on the development and implementation of their catch-up plans. Implementation was based on the WHO's 2016 guidelines for preventing and treating HIV, along with other evidence-informed strategies.

The WHO also provided a second tranche of funding in 2018, amounting to a cumulative total of approximately US$ 1 million in financing for the catch-up initiative. This was utilized to advocate for the strengthening of country ownership and sustained political commitment. It was also used for the execution of the WHO's Treat All policy for testing and treatment of everyone diagnosed with HIV, with a focus on execution at subnational (district) level. All 25[9] WCA countries adopted and implemented the policy.

The funding was also used to roll out to communities, innovative methods and technologies for the treatment and care of PLHIV, including differentiated service delivery (DSD), ensuring no stock-outs of test kits or ARTs, while facilitating resource mobilization in countries. In addition, the WHO continued to closely monitor implementation of the catch-up plans, through regular meetings with countries and technical partners to ensure alignment of efforts. The WHO also worked with governments to ensure that data collection and analysis provided high-quality information to guide decision-making. Towards the end of 2019, all WCA countries had commenced the execution of activities contained in their catch-up plans, in line with the WHO's testing and treatment guidelines.

The WHO Regional Office continued to support countries to implement their plans through to 2020. For example, of the funding provided by the WHO, US$ 70 000 was utilized in Cameroon to bring in technical experts for the scale-up of viral load testing and ART delivery, and to develop a community care model

9 Benin, Burkina Faso, Burundi, Cabo Verde, Cameroon, 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, Sao Tome and Principe, Senegal, Sierra Leone, Togo

2. The WCA HIV catch-up plan

for service provision. This also included advocating for decentralization, provision of free health care, and reinforcement of service delivery standards and procedures. As a result of this support, the Treat All strategy was implemented in four[10] regions. This technical assistance to health staff led to increases in the number of districts providing comprehensive HIV services, from 33 to 91 by 2019. The country was also able to extend PMTCT Option B+ protocols, which saw all expectant mothers living with HIV immediately offered treatment for life, regardless of their CD4 counts. The country increased the number of PLHIV who know their status to 78%, including 60% of infants exposed to HIV, by 2020. Option B+ aims to prevent vertical transmission of HIV from expectant mothers living with the disease to their unborn children. Health authorities were also able to reach out to about 90% of PLHIV who had either defaulted or discontinued treatment, getting them back on ART.

About US$ 36 000 was given to Chad to enable expert support for the procurement of ART and to strengthen the supply management system. In addition, the WHO supported the training of health workers on differentiated service delivery (DSD), provided technical assistance at the district level, and facilitated resource mobilization efforts. The technical support provided by the WHO was crucial in helping Chad get approval for a funding request from the Global Fund. It also helped the country to adopt the Treat All policy, DSD care model, new WHO guidelines on HIV treatment, as well as improved the procurement system and stabilized ART supplies. Cote d'Ivoire and Ghana received US$ 73 664 and US$ 74 600 respectively. These funds were used to implement the Treat All strategy, to strengthen service delivery standards and procedures, as well as to support the introduction of innovative technologies for care and treatment. This ensured the uninterrupted supply of basic supplies such as HIV test kits, and training for health workers in the treatment of TB/HIV co-infections, among other things. Cote d'Ivoire also adopted the DSD care model and implemented the transfer of certain tasks to community health workers to improve service access. The number of people accessing treatment in the countries increased by 37% and 35% respectively. This raised ART coverage to 73% for Cote d'Ivoire and 63% for Ghana by 2020. Although this coverage varies greatly across the countries, several districts were achieving up to 90% percent, with others significantly lower.

In addition, the WHO supported Guinea with US$ 30 600 which was utilized to support the country's national laboratory system to scale up viral load testing and ART coverage, especially for key populations such as infants, pregnant women and those with HIV/TB co-infections. The WHO supported Guinea to scale up prevention services with outreach to key populations, and to advance PMTCT interventions by incorporating these into 25 additional health facilities, and training 274 health professionals in the provision of PMTCT services. Liberia was given US$ 20 000 to develop a community testing strategy, while Sierra Leone received US$ 15 000 to conduct a national ART inventory following the Ebola outbreak, and to train health workers on the PMTCT B+ strategy. Liberia has implemented the DSD care model in three counties, integrating HIV, viral hepatitis and TB services, and rolling out PMTCT interventions in several health facilities. HIV testing increased by 16%, with up to 63% of PLHIV knowing their status by 2020. Sierra Leone implemented the PMTCT B+ strategy, resulting in expanded access to ARTs for pregnant women living with HIV, with up to 51% covered during the period. Technical support from the WHO also enabled Sierra Leone to carry out a treatment retention and survival analysis, which was utilized in the development of its DSD care model.

10 East, North, Central and Littoral

3 Implementation results

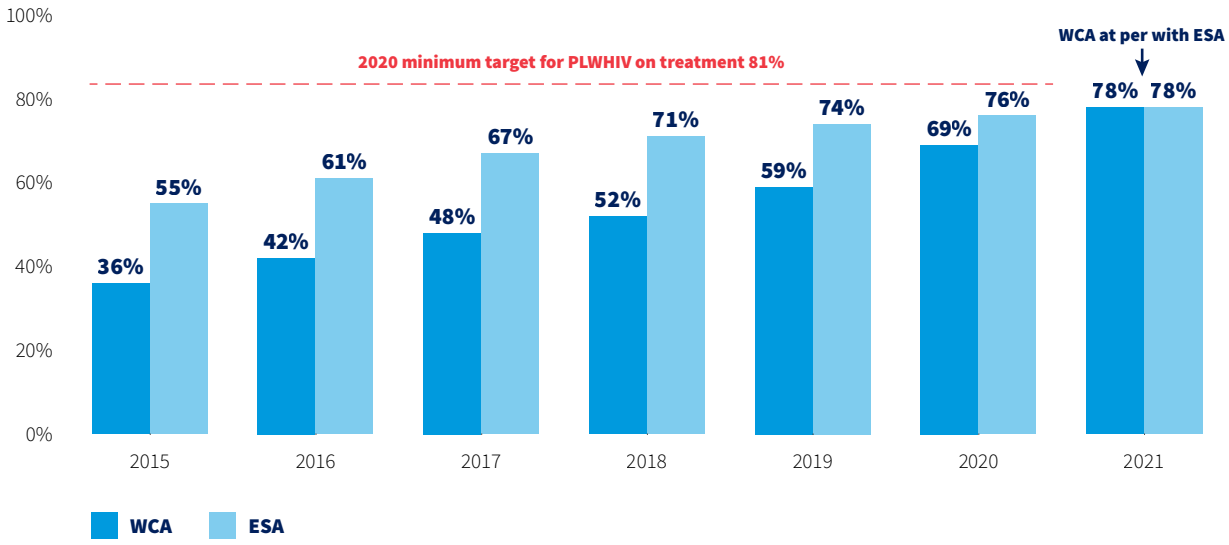
3. Implementation results

The WCA catch-up initiative achieved its target of drawing level with the ESA rates, albeit beyond the time frame and slightly below the 90-90-90 global HIV target for 2020. Although the catch-up and fast-track target was realized in 2021 as opposed to 2020, significant progress was observed between 2015 and 2020. The following sections demonstrate the progress on essential indicators made between 2015 and 2020, including the percentages of people on ART, those who know their HIV status, as well as those who are virally suppressed. The analysis utilized 2015 as a baseline for measuring progress in HIV control in WCA, and compared it with ESA's achievements. Other indicators that were considered included trends around new infections and AIDS-related deaths, including achievements in eliminating MTCT of HIV during the review period.

1.6 million more PLHIV enrolled on ART

The WCA catch-up initiative's target of matching ESA was achieved at the end of 2021 (Figure 3.1).

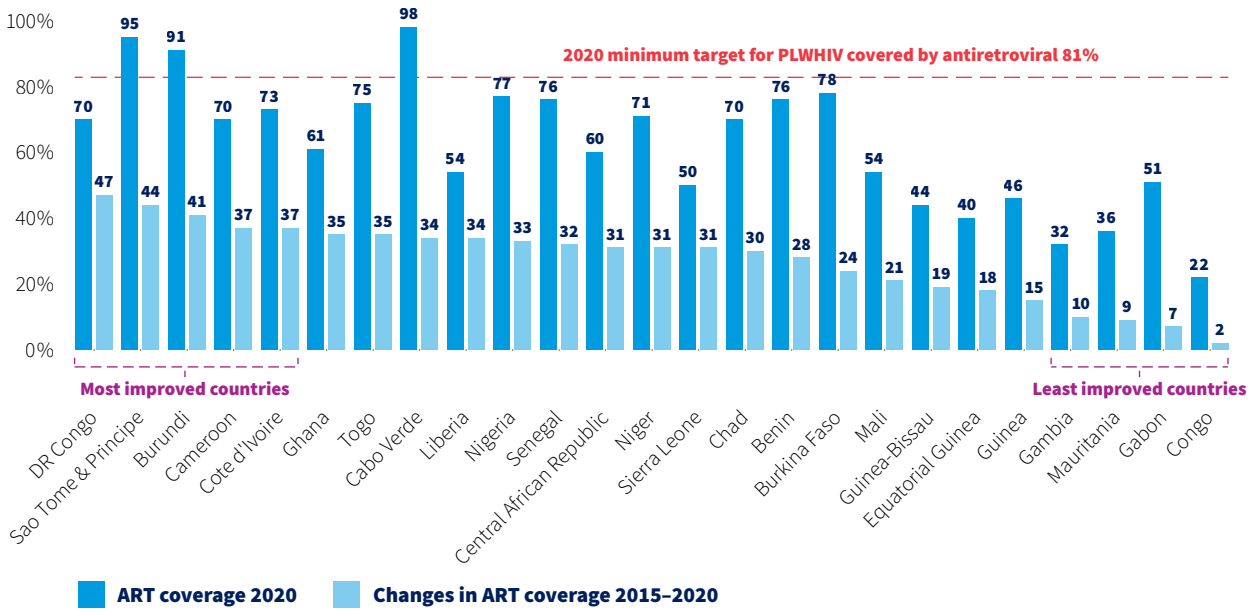
Figure 3.1 Shows significant progress ART coverage, with WCA drawing level with ESA at the end of 2021



Progress has been impressive over the period (2015–2020), with an additional 1.6 million PLHIV enrolled on ART. Generally, there has been more progress in WCA than ESA within the same period: An improvement of 33% was achieved between 2015 and 2020 in WCA, against 21% in ESA. In 2020, WCA was at 69% and ESA at 76%. But by 2021, WCA had drawn level with ESA, and both were at 78%, despite increases in testing and diagnosis. This marked a considerable increase of 42% in WCA, compared to ESA's 23% between 2015 and 2021. However, progress in countries within the WCA subregion varied widely, between a significant 47% in the DRC, to as low as 2% in the Republic of Congo (Figure 3.2).

3. Implementation results

Figure 3.2 Variation of improvements in people on ARTs in countries, and status, in 2020



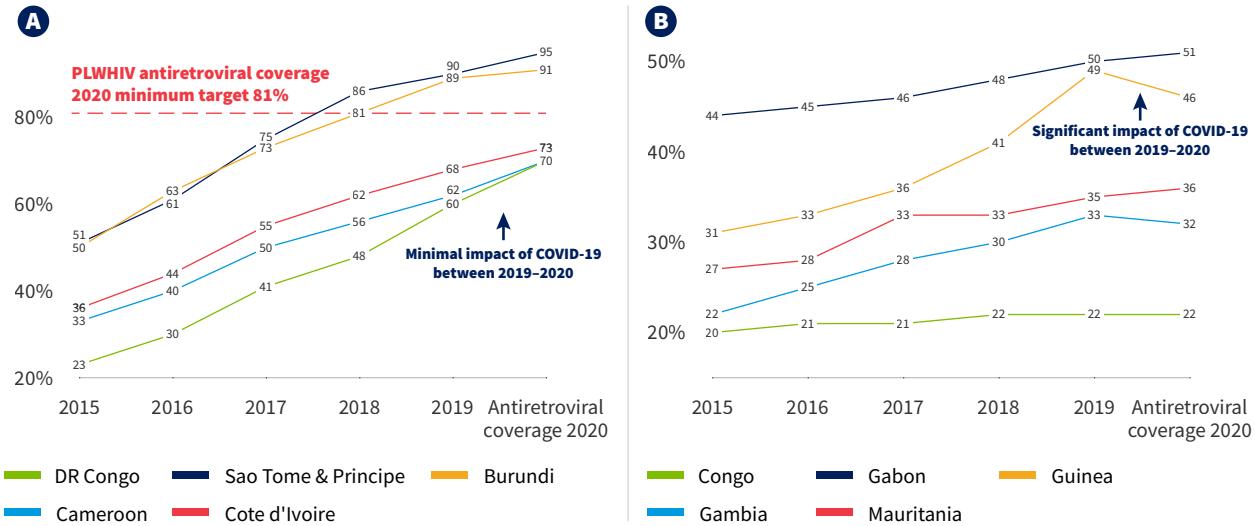
Cabo Verde (99%), Sao Tome & Principe (95%) and Burundi (91%) were the only three countries to achieve or surpass the minimum 81% target. Ten[11] additional countries achieved between 69% and 77%. The most improved countries were the DRC (47%), Sao Tome & Principe (44%), Burundi (41%), Cameroon (37%), and Cote d'Ivoire (37%) (Figures 3.2 and 3.3A). The lowest improvements were recorded in the Republic of the Congo (2%), Gabon (7%), Mauritania (9%), The Gambia (10%) and Guinea (15%) (Figure 3.3B).

Furthermore, comparing results achieved between 2019 and 2020 for the two subregions, the COVID-19 pandemic appeared to have had minimal impact on the most improved countries, despite its disruptive nature in some countries amongst the least improved group, such as Guinea. This suggests differences in countries' capacity to mitigate the impact of COVID-19, which in turn impacted the level of progress achieved at the end of 2020 and 2021 (Figure 3.3B). This was partly attributed to the adoption of the differentiated service delivery (DSD) approach, which helped ensure uninterrupted access to care and treatment for PLHIV by reducing the impact of pandemic disruptions.

11 Benin, Burkina Faso, Chad, Cote d'Ivoire, Cameroon, Democratic Republic of the Congo, Niger, Nigeria, Senegal, Togo

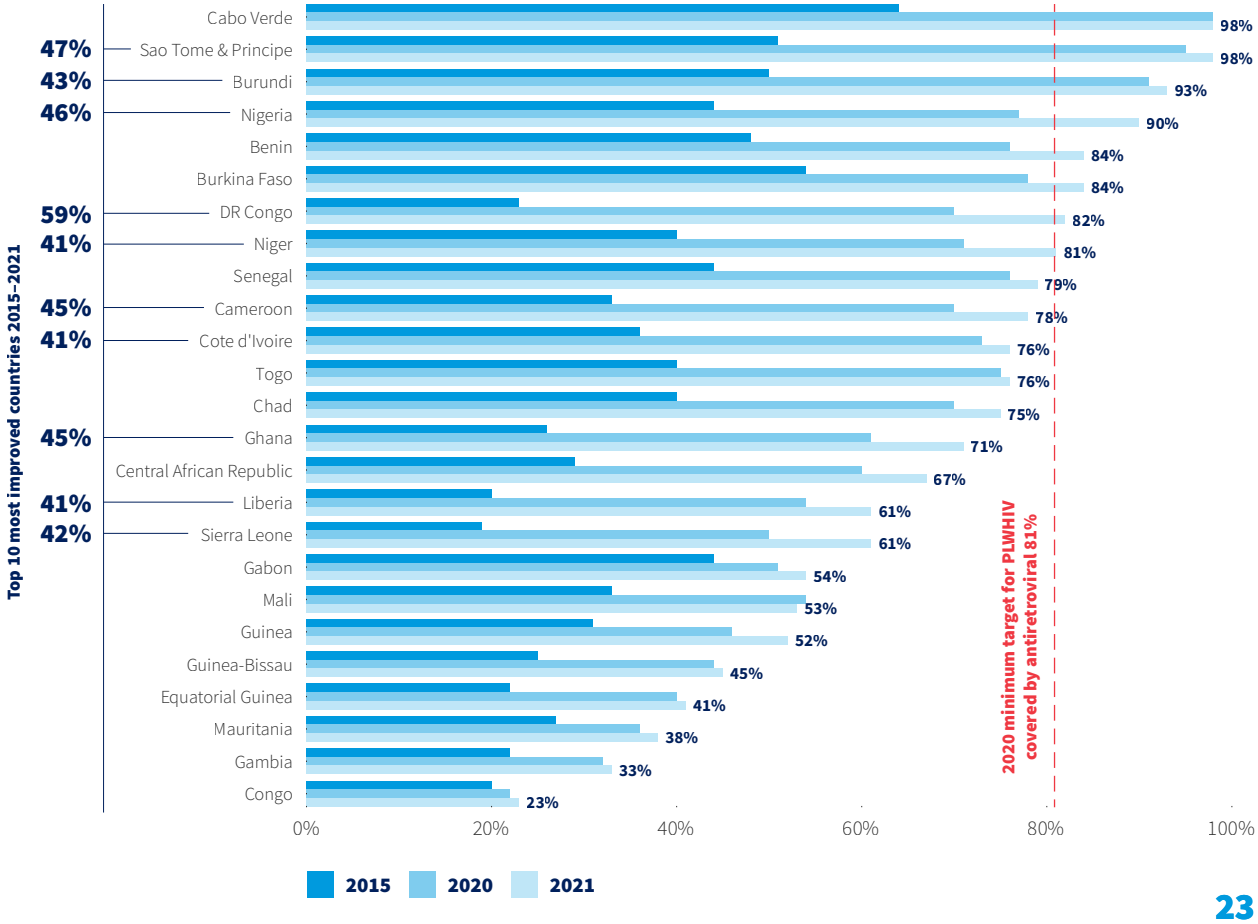
3. Implementation results

Figure 3.3 Shows (A) most and (B) least improved countries for ARTs coverage



Several countries continued to improve their response during the pandemic, notably Nigeria and Ghana, which improved ART coverage by 13% and 10% respectively from 2020 to 2021 (Figure 3.4). Comparing improvements in antiretroviral treatment between 2015 and 2021, the DRC (59%) remained the most improved country in WCA.

Figure 3.4 Compares improvements in antiretroviral treatment in 2020 and 2021, against 2015

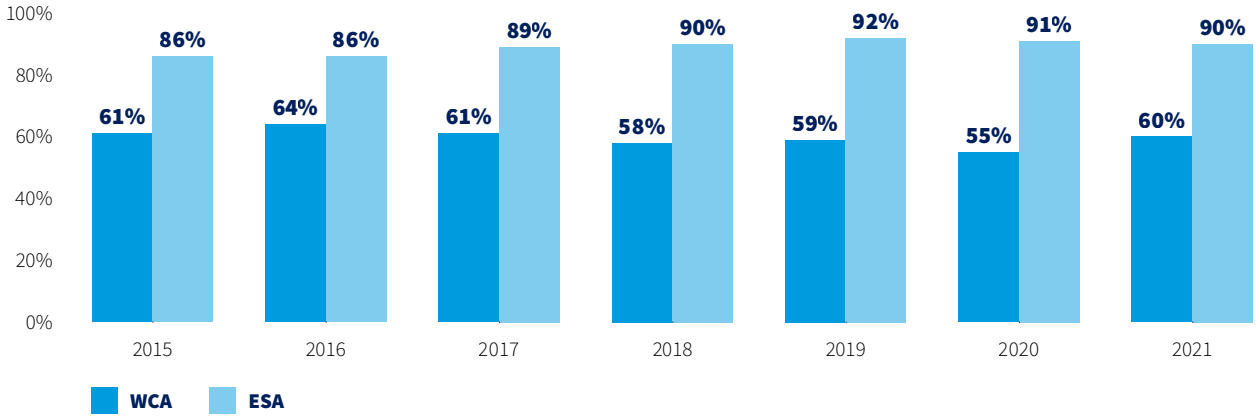


3. Implementation results

Striving to eliminate mother-to-child HIV transmission

Another important goal for increasing ART coverage was to eliminate mother-to-child transmission of HIV, or achieve a reduction to less than 5%. Over the years, ESA has generally progressed better than WCA (Figure 3.5), but improvements in neither subregion have been consistent between 2015 and 2021. WCA recorded a -6% decrease, and ESA a mere 5%. At the end of 2021, WCA had noted a further 3% increase, while ESA saw a 1% decrease, taking the cumulative progress from 2015 to 2021 to -1% and 4% for WCA and ESA respectively.

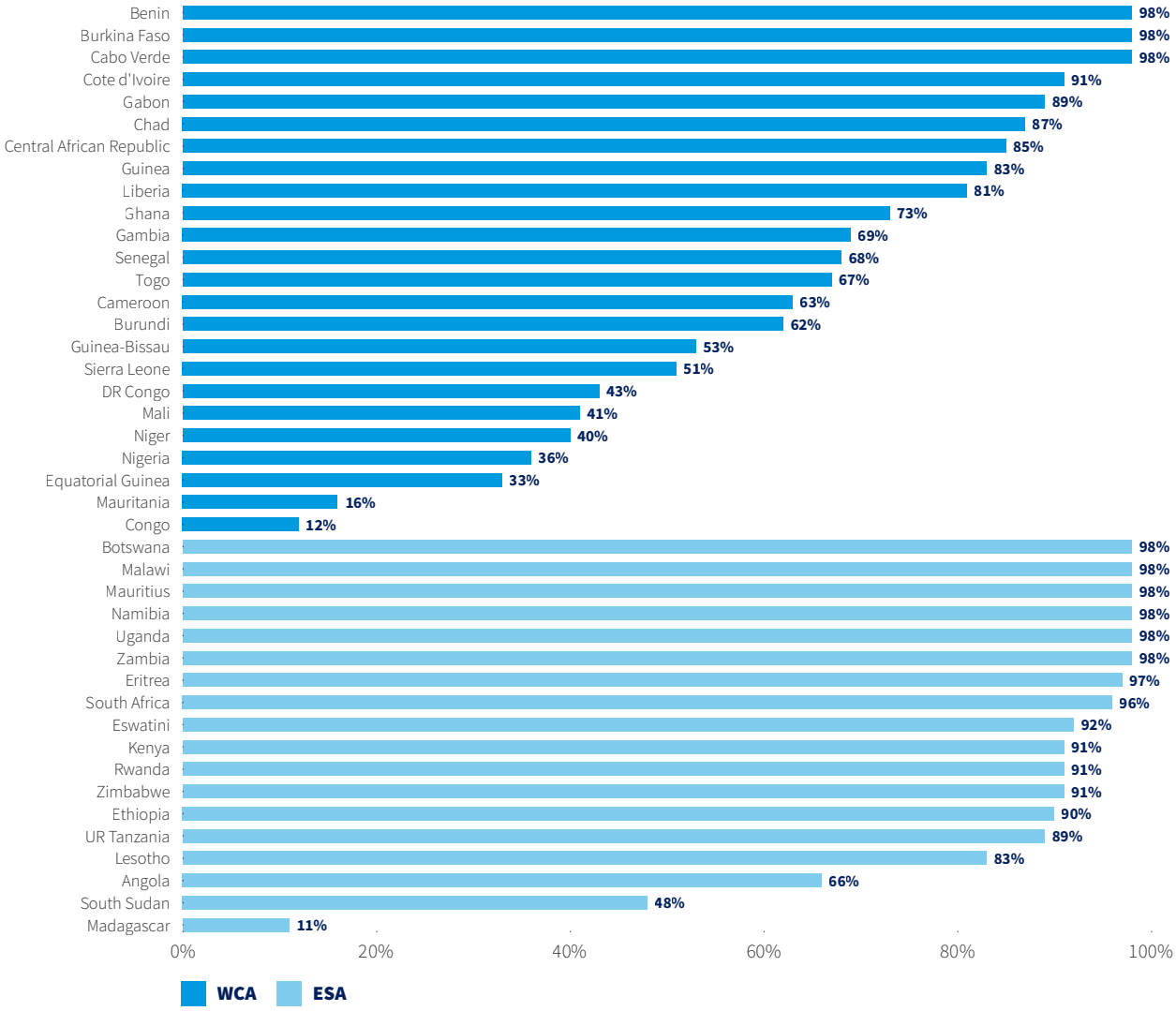
Figure 3.5 Progress in WCA and ESA highlighting better results from the latter between 2015 and 2020



Comparing countries in both subregions in 2020, Figure 3.6 shows that more ESA countries (8) have achieved over 95%, compared to only three in WCA. Another five ESA countries are between 90% and 95%, approaching the set minimum target of 95%, compared to only one in WCA. The approach to the PMTCT strategy in WCA needs to be revised and improved, including the incorporation of lessons learned from ESA countries.

3. Implementation results

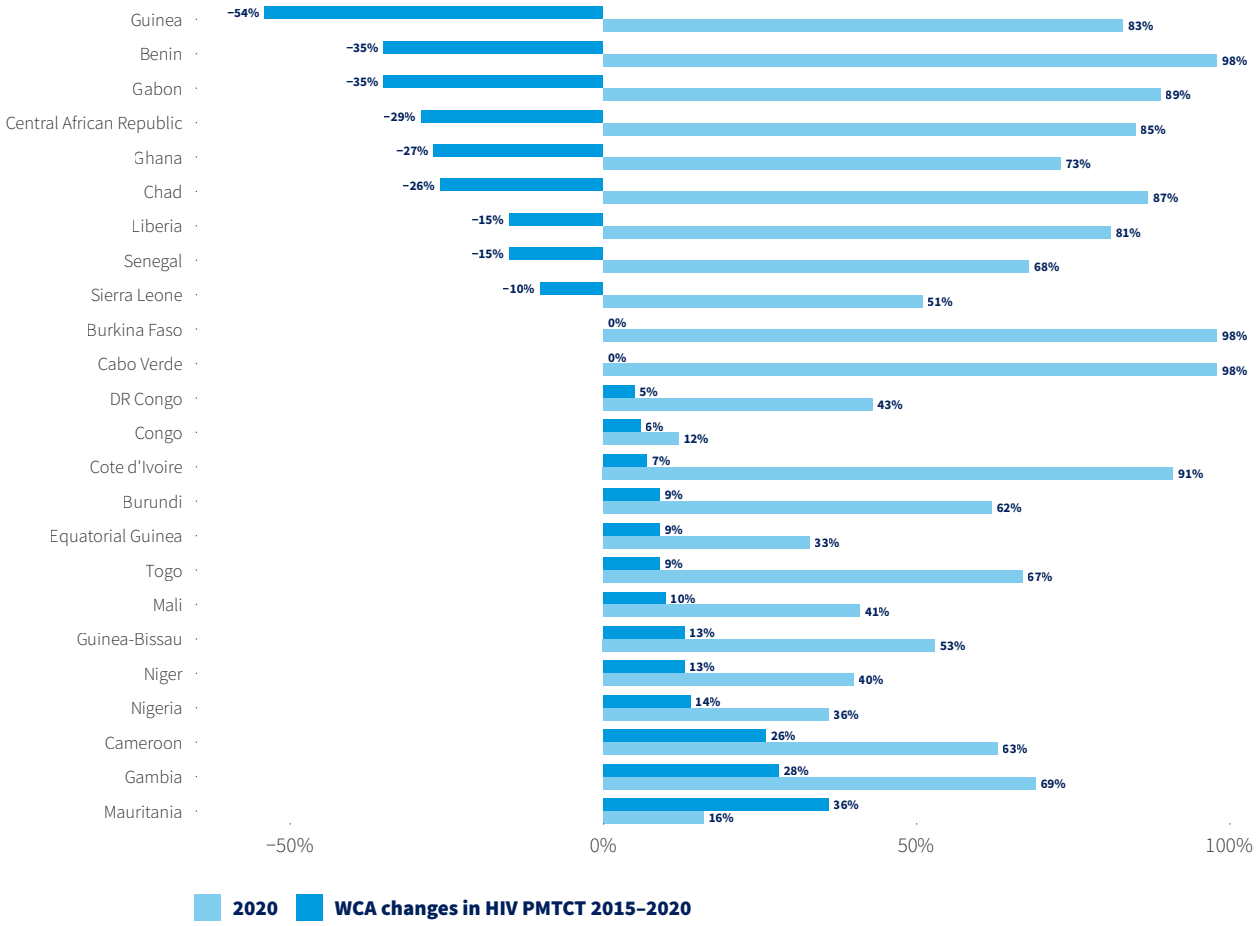
Figure 3.6 Comparing progress in ESA vs WSA for pregnant women on ARTs in 2020



Despite the inability to reach the target and the mediocre performances of WCA countries, Guinea (-54%), Benin (35%) and Gabon (35%), among others, have shown significant improvement. However, others, like Mauritania (36%), The Gambia (28%) and Cameroon (26%), have achieved the least improvements (Figure 3.7).

3. Implementation results

Figure 3.7 Highlighting progress in PMTC HIV transmission between 2015 and 2020



More people living with HIV know their status

The HIV catch-up plan aimed to significantly increase ART coverage in WCA to match the levels achieved by ESA. However, to achieve this goal, people's HIV status must be ascertained, which requires them to be tested. As such, increased treatment coverage also means increased testing. This push has translated into 22% more PLHIV across WCA knowing their status between 2015 and 2020, up from 50% in 2015 to 72% in 2020. This number increased to 80% by the end of 2021, marking an overall improvement of 30% between 2015 and 2021 (Figure 3.8). More women than men appear to have been tested, partly due to the policy of screening all pregnant women. This has resulted in more women than men knowing their HIV status.

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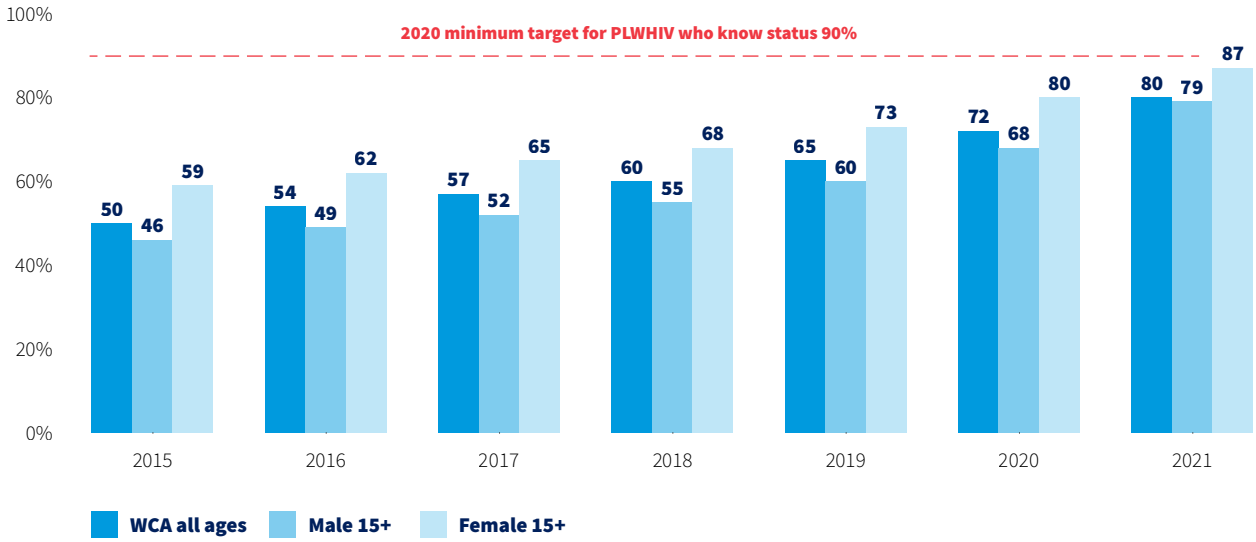
Figure 3.8 WCA progress in the percentage of people who know their HIV status between 2015–2021



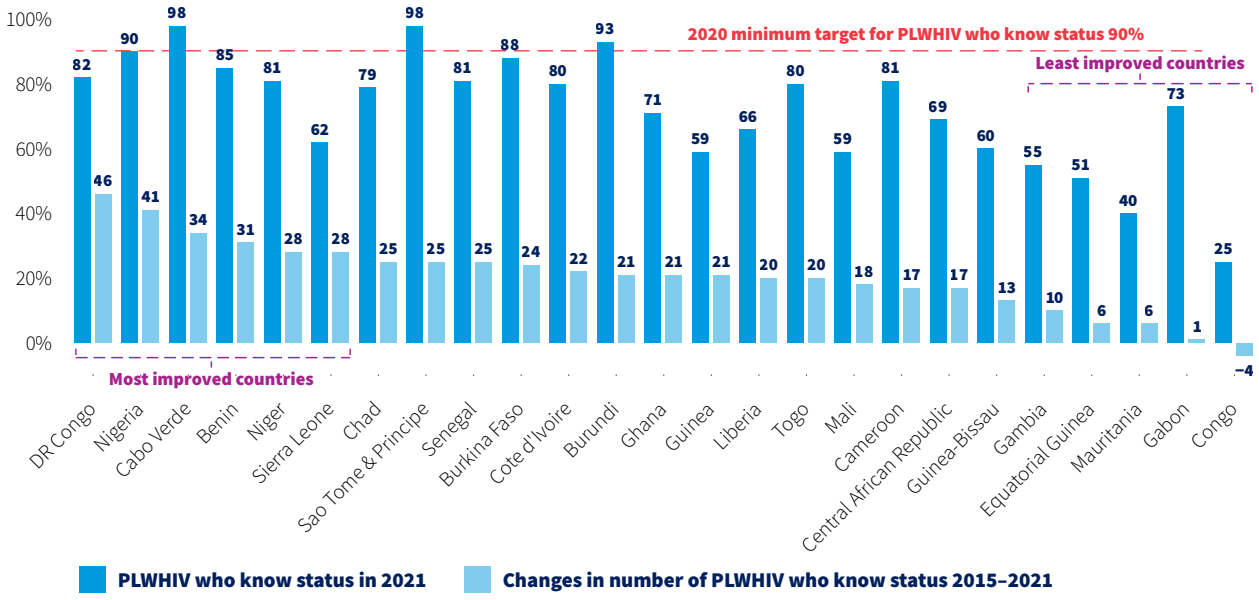
Despite meaningful progress, this achievement fell short of the 2020 minimum target of 90%, by about 18% at the end of 2020. However, improvements across WCA countries varied (Figure 3.9), ranging between 46% for the DRC, to 1% for Gabon and a -4% negative performance in the Republic of the Congo (Congo). The graphic also shows that Burundi, Cabo Verde, Nigeria and Sao Tome & Principe were the only countries to achieve or surpass the minimum testing target of 90% for PLHIV who know their status by 2021. Benin and Burkina Faso also came close to the target, at 85% and 88% respectively.

The most improved countries were the DRC (46%), Nigeria (41%), Cabo Verde (34%) and Benin (31%), with Niger and Sierra Leone both at 28%. This points to a significant increase in HIV testing in these countries (Figures 3.9 and 3.10A). The lowest improvements were observed in The Gambia (10%), Equatorial Guinea (6%), Mauritania (6%), Gabon (1%) and Congo (-4%) (Figures 3.9 and 3.10B). It is worth noting that among

3. Implementation results

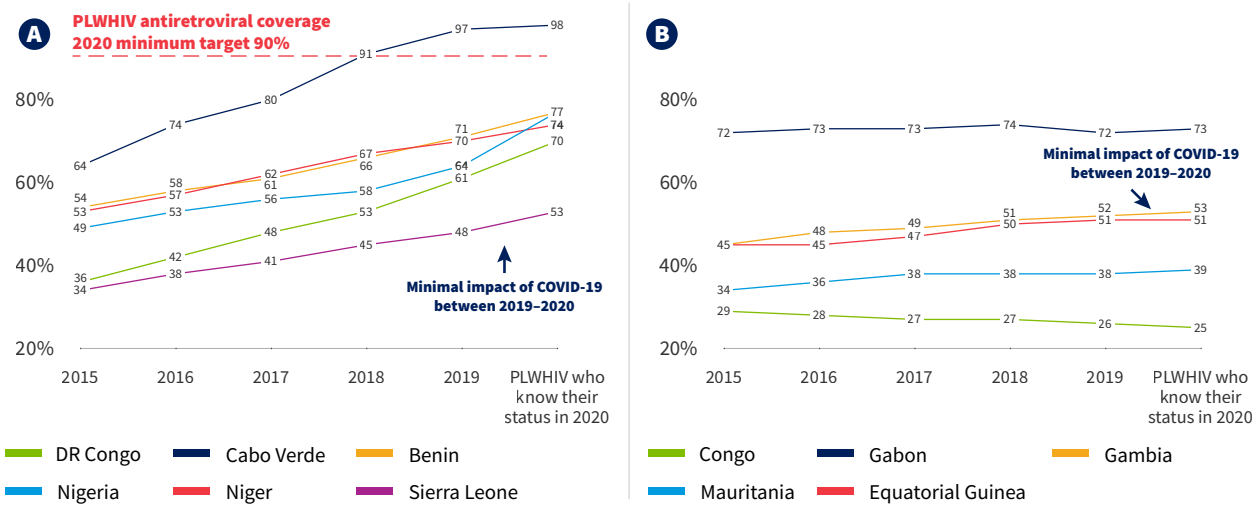
the least improved countries, Gabon achieved 73% by the end of 2020, but had already been at 72% in 2015. This indicates that progress was basically stagnant in that country throughout the period under review. The same applies to other countries in the group, but all were at a lower threshold in 2015.

Figure 3.9 Demonstrates variation in country performance across WCA for people who know their HIV status, highlighting most improved countries



Also, several countries are progressing towards the 90% target, with nine[12] additional countries achieving between 70% and 82%. Among both the most and least improved countries, COVID-19 did not appear to have had a significant negative effect on performance between 2019 and 2020.

Figure 3.10 Shows trends for people who knew their HIV status between 2015 and 2020, highlighting the impact of COVID-19 in (A) most improved countries and (B) least improved countries



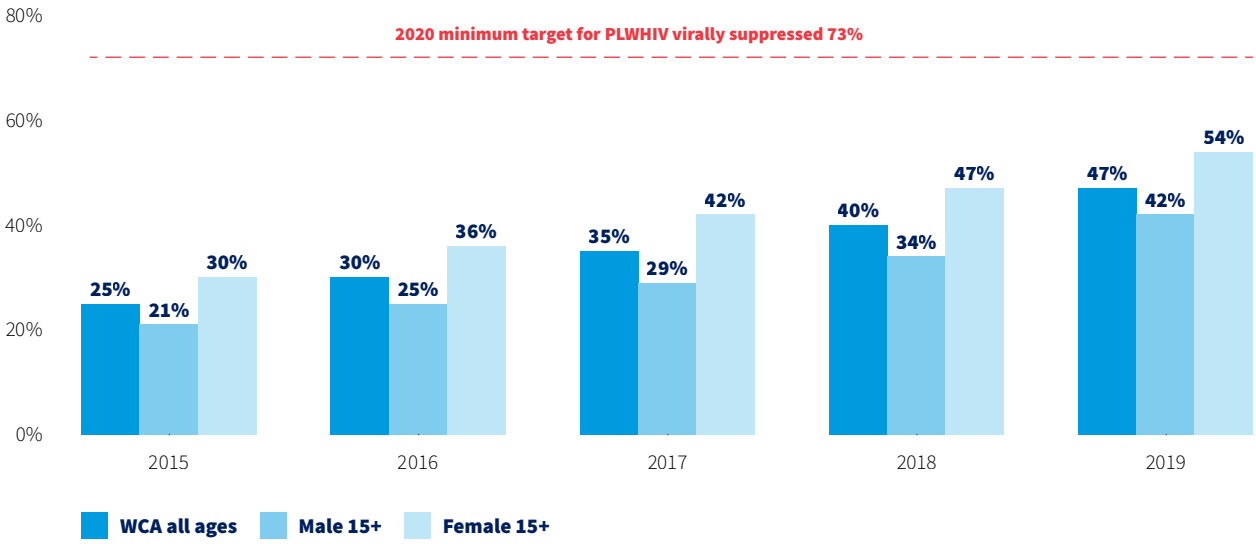
12 Chad, Cameroon, Cote d'Ivoire, Democratic Republic of the Congo, Gabon, Ghana, Niger, Senegal, Togo

3. Implementation results

Rising number of PLHIV achieving viral suppression

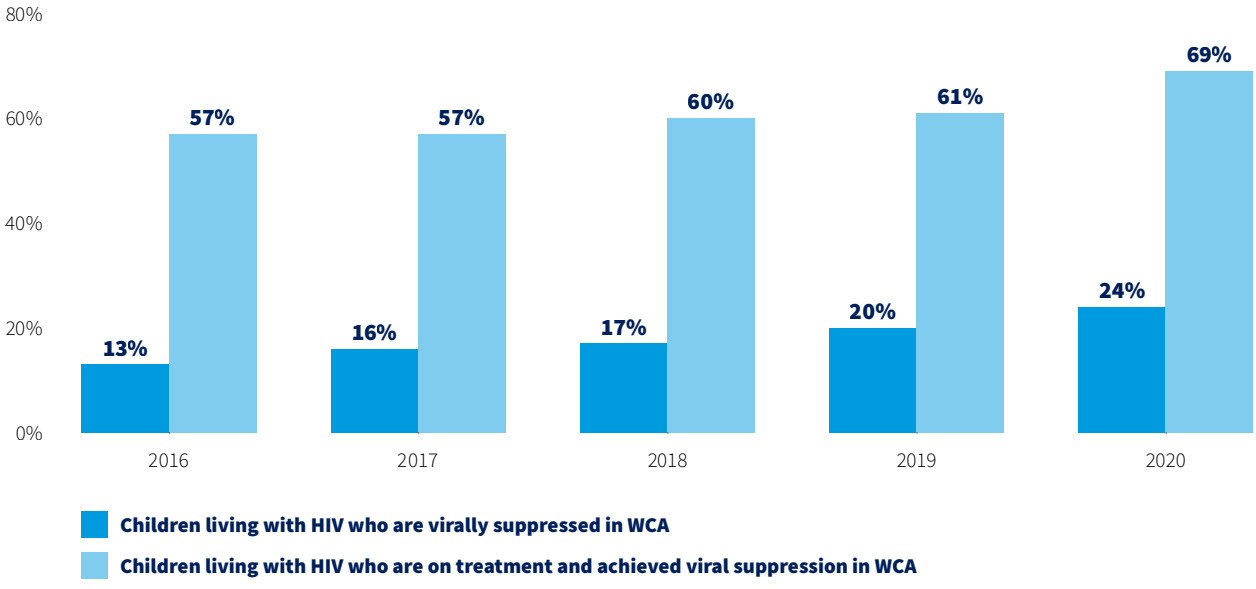
As more people are put on treatment, the number of PLHIV achieving viral suppression rose (Figure 3.11). More adult women than men achieved viral suppression in 2015 (30% vs 21%), rising to 54% and 42% respectively by 2019 in WCA.

Figure 3.11 Increasing number of PLHIV becoming virally suppressed in WCA 2015-2019



In addition, data also indicate that the number of children (0-14) living with HIV who have achieved viral suppression rose between 2016 and 2020. Although the rate was still lower than expected, it almost doubled (from 13% to 24%), marking an 11% increase over the period (Figure 3.12).

Figure 3.12 Rising numbers of children (0-14) living with HIV in WCA who are virally suppressed, and increasing percentage of children on ARTs who achieved viral suppression from 2016-2020

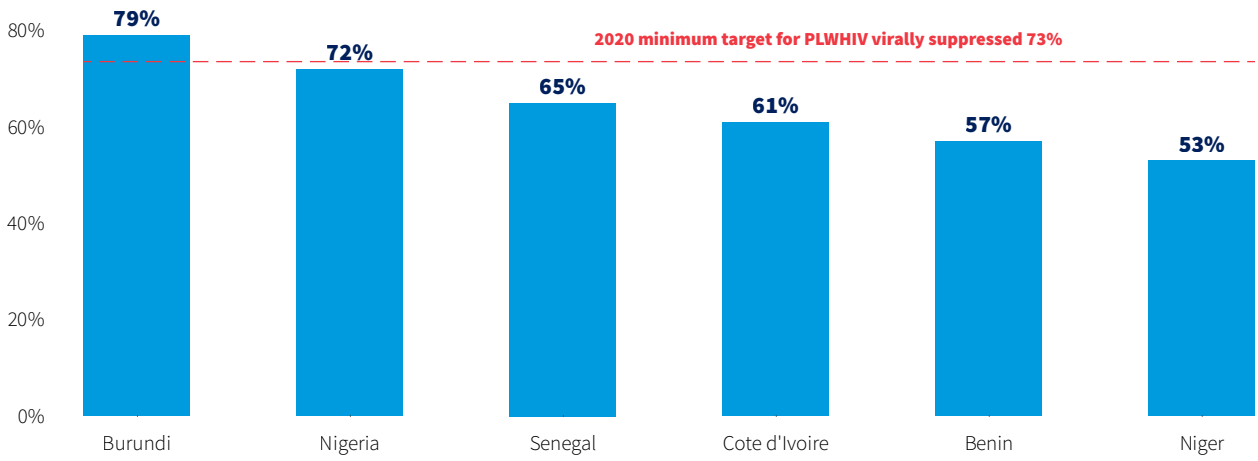


3. Implementation results

The main gap in the WCA subregion has been amongst children living with HIV but not receiving optimal ART. Once children are identified, tested and placed on treatment, most of them appear to do well. The percentage of these children who are on antiretroviral treatment, and have achieved viral suppression, increased from 57% in 2016, to 69% in 2020 (Figure 3.12). This indicates the need to promote the incorporation of effective services to boost the diagnosis rate of children living with HIV, with the goal of placing them on treatment. This would go a long way to closing the HIV treatment gap for children (0-14 years), and increasing the numbers who have achieved viral suppression.

While there was insufficient data for several countries, the limited data on people living with HIV who had achieved viral suppression that was accessed demonstrated that only Burundi has achieved or surpassed the 2020 minimum target (73%) for PLHIV who are virally suppressed in WCA (Figure 3.13). Nigeria, at 72% by 2020, almost reached the target, followed by Senegal (65%) and Cote d'Ivoire (61%).

Figure 3.13 Shows PLHIV who are virally suppressed, highlighting countries that reached the minimum target

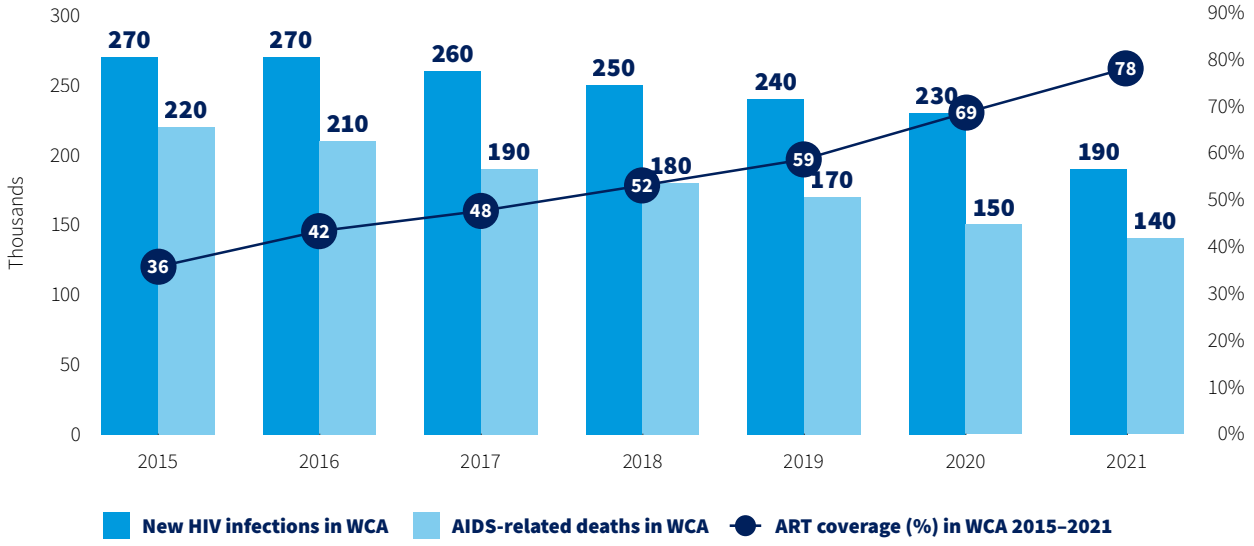


3. Implementation results

Declining new HIV infections and AIDS-related deaths

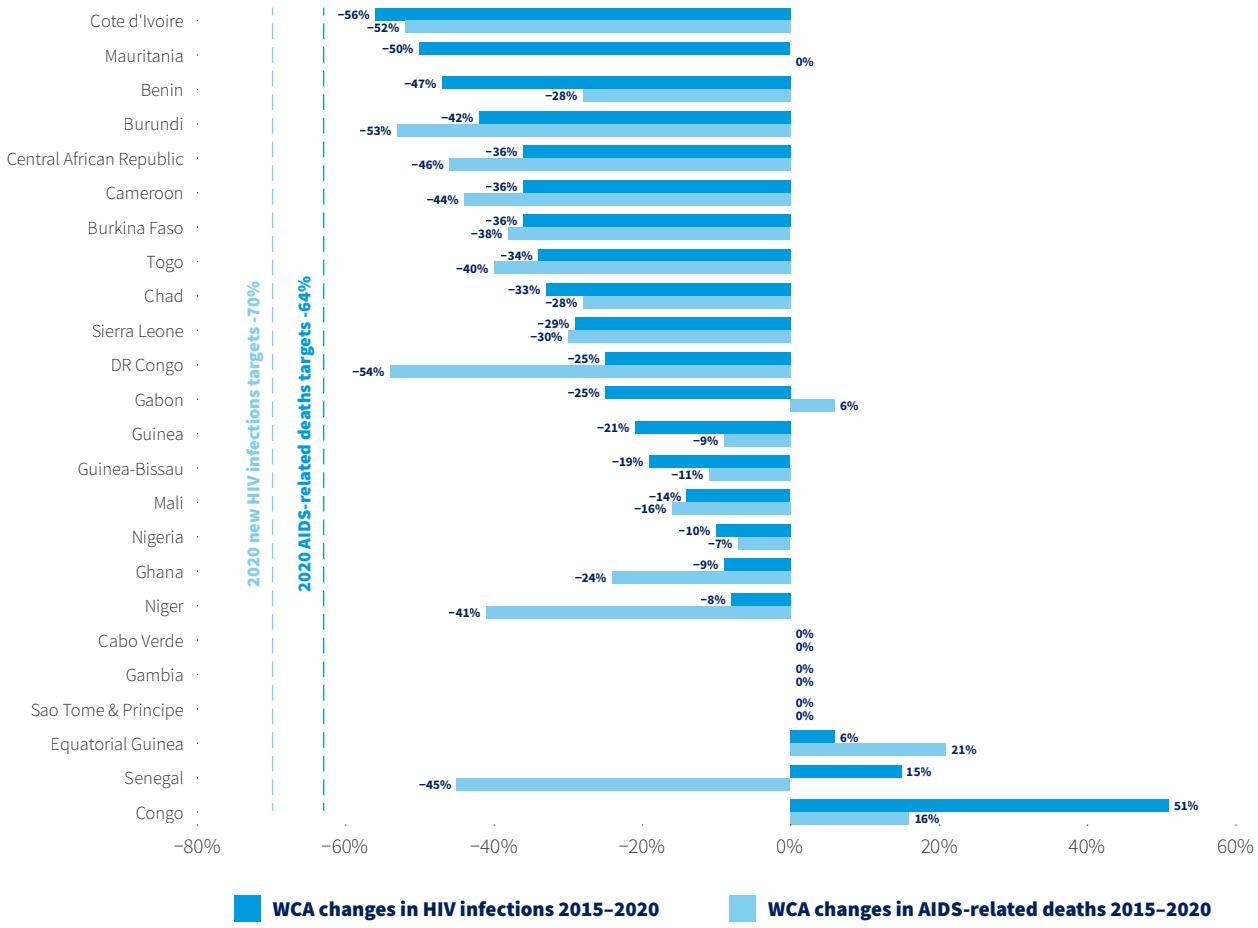
As ART coverage improved in WCA, more people with HIV are living longer and the number of AIDS-related deaths is decreasing. There seems to be an inverse relationship between increases in ART coverage and decreasing numbers of deaths of people with HIV-related ailments (Figure 3.14). The graph demonstrates the continual increase in ART coverage, from 36% to 69%, corresponding with a decrease, from 220 000 to 150 000, in AIDS-related deaths between 2015 and 2020. Another observation was the decreasing number of new HIV infections, from 270 000 to 230 000, over the same period. In addition, significant changes occurred in several WCA countries during the implementation of the catch-up plan between 2015-2020 (Figure 3.15).

Figure 3.14 Highlighting falling rates of new HIV infections and AIDS-related deaths, alongside increasing ART coverage



3. Implementation results

Figure 3.15 Shows significant changes in rates of new HIV infections and AIDS-related deaths in various countries



Improvements in the rate of new HIV infections ranged from -56% in Cote d'Ivoire and -8% in Niger, to 15% in Senegal and 51% increase in the Congo. Changes in the rate of AIDS-related deaths ranged from -51% in the DRC and -7% in Nigeria, to a 16% increase in the Congo and 21% in Equatorial Guinea. Nigeria recorded the highest number of both new infections and AIDS-related deaths in 2020 (Figure 3.16). The top four countries accounted for 64% of all AIDS-related deaths in 2020, and 71% of all new HIV infections in WCA. All four countries appear in the same order in both categories.

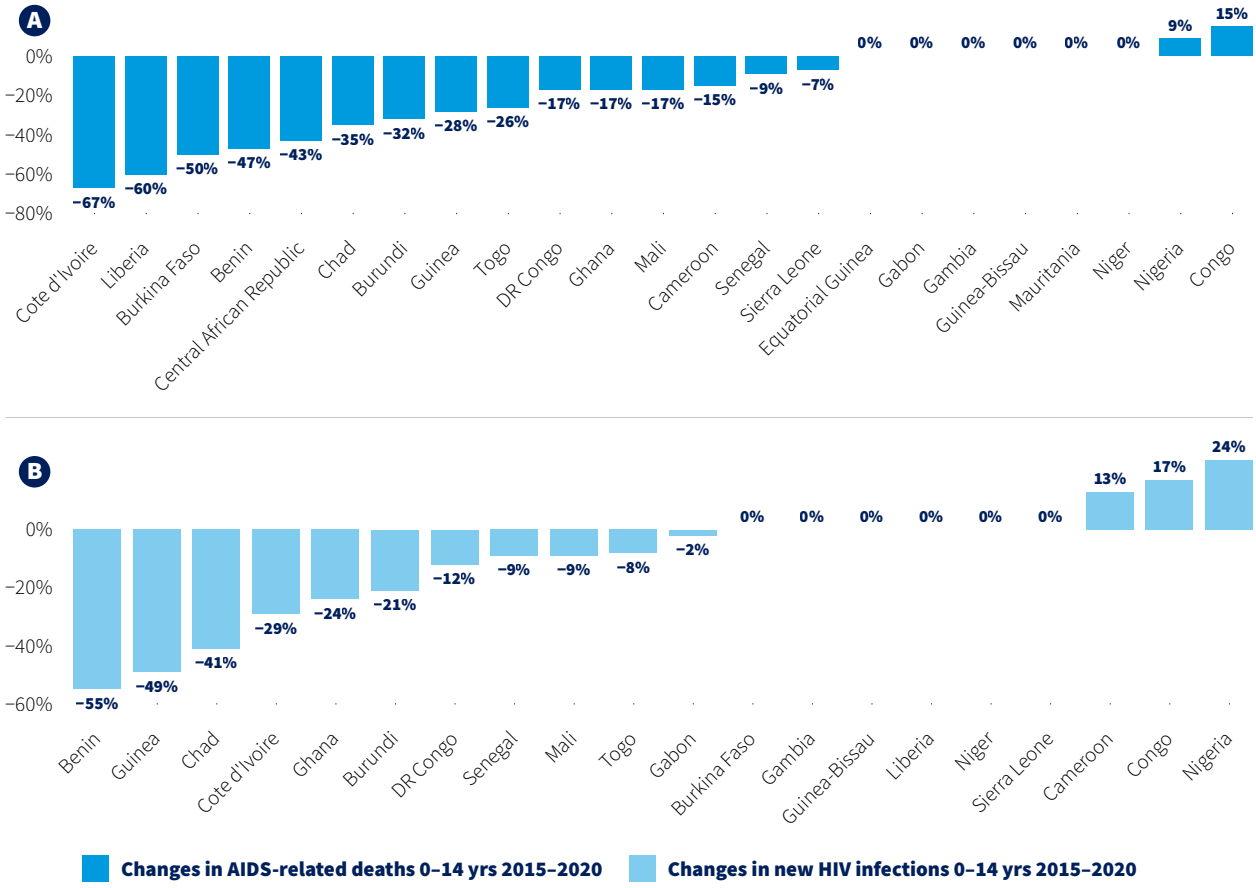
Figure 3.16 Highlights the top four WCA countries for AIDS-related deaths and new HIV infections

WCA AIDS-related deaths in top 4 countries			WCA new HIV infections in top 4 countries		
Country	**2020**	**2021**	**Country**	**2020**	**2021**
1. Nigeria	56 000	51 000	1. Nigeria	99 000	74 000
2. DR Congo	16 000	14 000	2. DR Congo	24 000	21 000
3. Cameroon	14 000	13 000	3. Ghana	20 000	17 000
4. Ghana	13 000	9 900	4. Cameroon	16 000	15 000

3. Implementation results

Furthermore, decreases in AIDS-related deaths among children (0-14 years) ranged between -67% in Cote d'Ivoire to -7% in Sierra Leone, with a 15% increase in the Congo (Figure 3.17A). Several countries, including The Gambia and Mauritania, saw no reduction in AIDS-related deaths.

Figure 3.17. Shows (A) changes in AIDS-related deaths (B) new HIV infections among children, 2015-2020



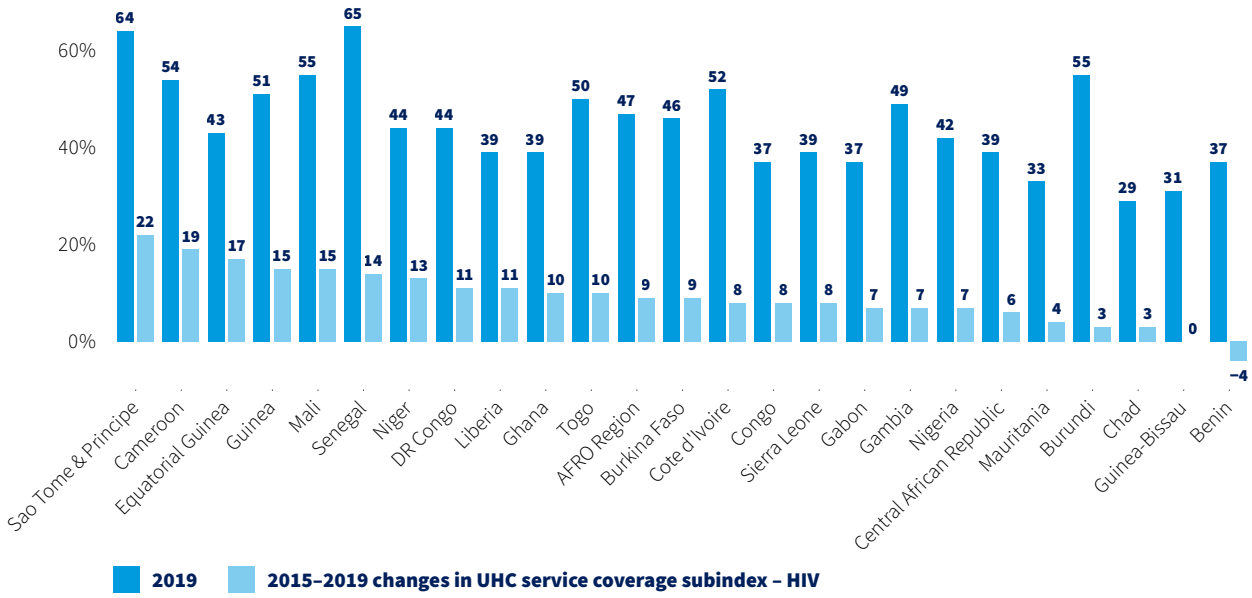
For new HIV infections, decreases recorded ranged from -55% in Benin and -2% in Gabon, while increases of 24% were seen in Nigeria and 17% in the Congo. Countries including Liberia and Niger, among others, made zero progress over the same period (Figure 3.17B).

3. Implementation results

HIV catch-up's contributions to UHC service coverage index

WCA Universal Health Coverage (UHC) index data for the period to 2019 has been assessed and revealed that modest progress was achieved over the period 2015–2019. Improvement varied significantly between countries, from 22% in Sao Tome & Principe, to 3% in Chad (Figure 3.18). Despite this progress, the pace of change, especially in countries with low UHC service coverage, has been inadequate. Countries with relatively high UHC index, such as Burundi (55%), Cote d'Ivoire (52%) and Togo (50%), had also not recorded substantial improvements by the end of 2019.

Figure 3.18 Demonstrates UHC service coverage progress in several countries from 2015–2019



4 Notable examples of catch-up plans implementation in countries

4. Notable examples of catch-up plans implementation in countries

To highlight examples of country results, Cote d'Ivoire, the DRC and Nigeria were selected, based on important actions taken and improvement rates achieved within the period under review. These examples showcase key issues encountered, how these problems were tackled and resolved including their contributions to the performance of the WCA HIV catch-up plan and strategy.

Success factors responsible for progress towards achieving HIV objectives in the DRC

The DRC is one of the countries in the WCA subregion with a considerable HIV burden, an estimated 541 829 PLHIV by 2021. Historically, ART was initially introduced in a limited number of provinces between 2002 to 2003, via a public-private partnership arrangement. Due to availability of funding from the Global Fund and World Bank's Multi-Country AIDS programme (MAP), ART services were extended to other provinces in 2015, driven by the 3 by 5 Initiative. This enabled the development of national guidelines for ART, and implementation of plans for treatment expansion to other provinces. Despite these efforts, progress remained weak and by 2012, almost 10 years later, ART coverage had reached only about 12%.

However, from 2015 several changes were initiated, including the WCA catch-up and fast-track plan, with a goal to accelerating ART coverage rates. Other changes included the rationalization of partnerships, introduction of the test and Treat All policy, option B+, differentiated service delivery, and the prioritization of areas requiring intervention. In addition, the DRC benefited from an inter-agency mission in 2015 which included WHO, UNAIDS, the United States President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund, UNICEF and Médecins Sans Frontières (MSF), among others. Technical experts from the WHO's Headquarters and the Africa Regional Office supported the country to develop differentiated service delivery documents including implementation guidelines and recommended its use. The combination of these actions and strategies facilitated a threefold improvement in the ART rate for PLHIV between 2015 and 2020. This had almost quadrupled by 2021, marking a critical milestone and huge achievement in the fight against HIV in the DRC.

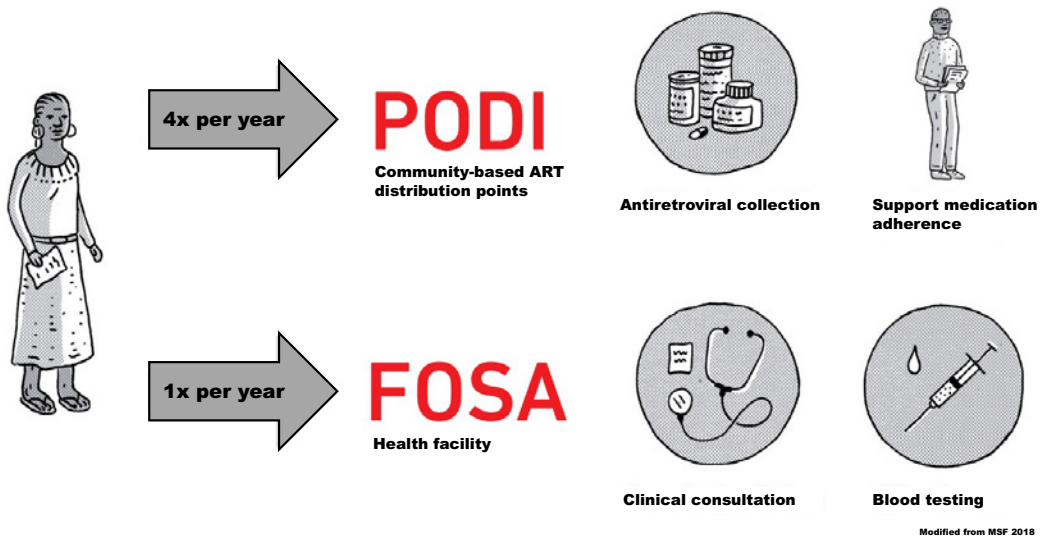
4. Notable examples of catch-up plans implementation in countries

Furthermore, the rationalization of partnerships was aimed at guiding and organizing partners with the intention of streamlining services and minimizing resource wastage due to the co-presence of several partners on the same sites, providing the same services, within the same health districts. For example, in 2015 the Global Fund reported covering 300 health districts, while PEPFAR reported 96. However, HIV interventions were only offered in 316 health districts. The goal of the rationalization exercise was to resolve problems such as this. After the conclusion of the process, the number of health districts covered increased to 344 in 2016, while the number of health facilities offering HIV interventions tripled over two years. As a result of this change, PEPFAR started paying for ART for PLHIV in health facilities, which had a significant impact on the availability of ART in the DRC. This expansion, coupled with the availability of services, also contributed substantially to improved ART coverage for PLHIV, which almost doubled in just two years, from 23% in 2015 to 41% in 2017.

During the same period, the implementation of the WCA catch-up and fast-track plan in the DRC to accelerate progress towards the 90-90-90 target by 2020, started in earnest. Ownership of these plans by the country, together with the implementation of strategies including expanded availability of services, targeting people to be tested for HIV, follow-up techniques for PLHIV, and ways to keep those on treatment in the system, contributed to a considerable acceleration of ART coverage in the DRC.

Similarly, a prioritization map of the provinces classifying them as high, medium or low priority, was utilized to ensure the provision of differentiated services based on need. Different sets of services were determined for each category of health district, with maximum attention paid to high-priority provinces such as Maniema, with a prevalence rate of up to 4%. These sets of services included community-based ART distribution points, known as PODIs (Points communautaires de distribution de TAR), multi-month distribution, the one-stop shop for tuberculosis and HIV, among others. The PODI model entailed people on ART collecting their medication from community distribution points run by trained PLHIV. Stable patients visit quarterly to replenish medications and receive support to stay on treatment. They also visit care clinics annually for clinical consultations and blood tests, known as FOSA (formation sanitaire). It is worth noting that PODIs also offer HIV testing (Figure 4.1).

Figure 4.1 Demonstrates drug dispensing models and patient follow-up in a PODI, as well as clinical consultations and blood tests in a FOSA



4. Notable examples of catch-up plans implementation in countries

As a result, PODI sites detected 391 positive cases in 2015 (19%), which is significantly higher than the detection rate in health facilities. Analysis carried out in 2016 showed that of the 44% of patients followed up at PODI, who had access to viral load testing, 96% had low viral loads. The retention rate was better than those of health facilities; 98% at six months, 95% at 12 months, and 91% at 24 months. By the first half of 2022, 74% of stable patients were benefiting from the DSD model, including 8% in PODIs and 75% in the clinical visits scheme. The one-stop-shop model has also facilitated the integration of HIV services with those of related diseases, such as tuberculosis (TB). The DRC produced a guide defining two one-stop-shop models, the “collaborative” and “integrated” versions, to enable training of service providers, and to designate ART sites as either Tuberculosis diagnostic and treatment centres (CSDTs) or Tuberculosis diagnostic centre (CSTs). ART sites that could not become CSDTs or CSTs were networked with CSDTs for HIV and TB screening and treatment. These models have enabled the training of service providers and facilitated the expansion of HIV care and ART services. Between 2015 and 2017, this allowed for 49% to 64.5% of TB patients to be screened for HIV. The proportion of TB patients who tested HIV positive, and were placed on ARTs, increased from 66% to 82.4% during the period.

Finally, the improvement of treatment protocols and criteria for starting treatment have also been critical to the progress, notably the test and Treat All strategy, along with DSD, targeted screening and the one-stop HIV/TB integrated service. Others included changes made to frontline drug regimens, which contributed notably to the improvement in viral load suppression from 74% in 2018, to 89% in 2021. This is believed to be a consequence of the introduction of dolutegravir-based therapeutic regimens. It should also be noted that the DRC has consistently been among the first French-speaking countries to adopt new WHO guidelines related to HIV.

4. Notable examples of catch-up plans implementation in countries

Nigeria's journey towards achieving the 90-90-90 HIV targets by 2020

Prior to the WCA catch-up initiative, HIV response in Nigeria was challenged by three major issues: poor data quality, low service coverage, and sub-optimal coordination and ownership evidenced by responses from donors. Coordination of the HIV programme was a challenge due to an ongoing standoff between the health sector coordinating platform (NASCP/SASCP)[13] and the multisectoral coordinating platform (NACA/SACA)[14], at both national and state levels. The last population-based survey (NARHS 2012)[15] put HIV prevalence among the country's adults (age 15-49) at 3.4%, with an estimated 3.2 million PLHIV. However, this survey was not widely accepted because of the unexplained high HIV prevalence variations for some states, compared to previous surveys.

It was therefore important to address the issue of poor data quality, with initial efforts focused on this problem. As a result, a National AIDS Incidence and Impact Survey (NAIIS 2018) was conducted, determining HIV prevalence of 1.3% in 2018, against 3.4% in 2012, and an estimated 1.8 million people living with the disease – the fourth highest HIV burden in the world. Routine data reporting systems were strengthened by streamlining and harmonizing the country's health sector HIV monitoring and evaluation (M&E) system. Fewer performance indicators were adopted, and harmonized. Facility-level data collection tools were reviewed, and health workers trained. The Electronic Medical Records (EMRs) and the District Heath Information System[16] platforms were integrated and strengthened. A National Data Repository (NDR) was established to provide real-time HIV data, allowing for case-based reporting.

To address low HIV service coverage, the catch-up plan and the SURGE capacity project were initiated to fast-track and intensify identification of PLHIV, and put them on treatment, in a group of states which accounts for >50% of the national unmet treatment needs. The WHO facilitated and provided guidance for the establishment and running of an HIV situation room to coordinate logistics of HIV commodities, and National Integrated Sample Referral Network (NISRN) systems for the mile-end distribution of HIV drugs and commodities. The DSD strategy has improved the overall experience of PLHIV at service points. This has ultimately improved patient retention in care, and reduced the burden on health systems. This was coupled with a clinical HIV mentorship programme for facility-level health workers, to strengthen service delivery capacity. By the end of 2020, these initiatives had led to an improvement in service coverage to 77%-98%-72% for those who knew their status, were on treatment, and whose viral loads were suppressed, respectively. By the end of 2021, those figures had risen to 93%-96%-89%.

Furthermore, to increase national ownership, ensure sustainability of the HIV response, and consolidate the gains, initiatives were put in place to bridge the coordination gap and improve leadership. One of these initiatives was the re-establishment of the National Treatment and PMTCT[17] programme (NTPP), aimed at strengthening the capacity of the health sector coordinating platform NASCP/SASCP to deliver on its mandates. For effective implementation and sustainability of HIV programmes, there was a need

13 NASCP/SASCP - National AIDS and STDs Control Programme / State AIDS and STI control programme
14 NACA/SACA - National Agency for the Control of AIDS/State Agencies for the Control of AIDS
15 National HIV&AIDS and Reproductive Health Survey
16 DHIS – District Health Information System
17 PMTCT - Prevention of Mother to Child Transmissions

4. Notable examples of catch-up plans implementation in countries

to strengthen the institutional capacity of the NASCP and State Ministries of Health (SMoH). This resulted in the establishment of the HIV health sector steering committee, chaired by the HMH[18], co-chaired by WHO and PEPFAR. These coordinating platforms, including technical working groups, were reviewed and strengthened. Regular staff change management retreats and institutional capacity assessment (NHOCAT) of NASCP and SmoH, were conducted. The capacity of NASCP and SMoH staff was strengthened, based on gaps identified by the NHOCAT. In turn, the NASCP began providing institutional/technical assistance to the SASCP/SmoH.

Finally, to improve sustainability and encourage ownership, the WHO facilitated the Global Fund and PEPFAR alignment project. This resulted in the Global Fund contributing US$ 180 million to the HIV commodity pool managed by PEPFAR. The initiative supported service delivery implementation in 32+1 states, including Abia and Taraba, while the Global Fund supports in two states. The HIV trust funds initiative, a domestic-private sector-driven effort, was also established. The WHO provided technical guidance for the development of national TB/HIV 2021–2023 funding requests, attracting US$ 451 311 921 in funds allocated for continuation of TB and HIV grants. At the end of 2021, Nigeria achieved the target, with 93% of PLHIV knowing their status, 96% of those who know their HIV status placed on ART, and 89% of those on ARTs successfully virally suppressed.

18 HMH – Head of the Ministry of Health

4. Notable examples of catch-up plans implementation in countries

District prioritization and monitoring as an effective recipe for increasing access to HIV testing and treatment in Cote d'Ivoire

Like several countries in the WCA subregion, Côte d'Ivoire agreed to pursue the 90-90-90 HIV targets by 2020. At the beginning of 2016, only 63% of PLHIV knew their status and only 46% were on ART. As a result, Côte d'Ivoire joined other countries in the subregion in developing a country-specific HIV catch-up and fast-track plan, and commenced implementation. Until late 2018, however, progress was slow.

Anxious to accelerate progress to maintain the trajectory towards the targeted objectives, an initial analysis of the national programme data informed the prioritization of 24 health districts, which represented approximately 75% of the gap, and the determination of specific efforts required if the objectives were to be met by 2020. As a result of the prioritization process, several actions were taken to accelerate efforts to achieve the planned targets, the first being the establishment of a consultation framework for primary technical and financial partners. This also included community actors, under the leadership of the national programme, to intensify support for districts and to monitor implementation of the catch-up plan. Monthly meetings were held for analysis and regular monitoring of progress in the 24 priority districts, and to identify barriers and determine coordinated solutions to promptly address the hurdles, and facilitate progress.

The second action involved regular monitoring of HIV results and progress at both national and regional level, under the leadership of the Ministry of Public Health. This included organizing monthly meetings of regional and district directors to monitor the progress of HIV indicators for six months, under the supervision of the Director General of Health, to inform corrective action should progress stall.

The third action was the establishment of a monthly planning-monitoring-rescheduling initiative for HIV interventions at district level. The goal was to continuously identify actions to boost the provision and use of services at both clinical and community sites. An Excel monitoring and micro-planning tool was developed for application at district level, while capacity building of district management teams began in four districts to advance results-based planning and monitoring of interventions. This was subsequently expanded to the remaining 20 districts.

Another vital element was the provision of technical support for the organization of monthly monitoring and reprogramming meetings with all site managers, as well as supervision at district level. The final element was support for the operationalization of sites and performance of purchasing systems in three districts. Indicators monitored included the number of new HIV cases detected, PLHIV placed on ART, as well as the number of cases lost but recovered through follow-up and placed back on treatment. These measures enabled Côte d'Ivoire to maintain progress towards achieving its set targets. The fourth action was the establishment of a mechanism for rapidly supplying sites and districts with screening tests kits.

As a result, six months after putting these actions in place, nearly 50% of the targeted PLHIV in three of the 24 districts had been screened and placed on ART. At nine months, that number had doubled to six districts, with more than 75% of the targeted PLHIV on treatment. This led to the extension of the monthly planning-monitoring-rescheduling initiative to most districts in Côte d'Ivoire. One of the key lessons learned was that the close monitoring of progress by district stakeholders made a huge difference, and that the capacity for obtaining rapid results significantly impacted the performance of the national HIV programme.

5 Barriers, challenges & lessons

5. Barriers, challenges & lessons

Regardless of the significant improvement in WCA to catch up with ESA, the improvement was insufficient to achieve the 2020 minimum target of 81% ART coverage in the whole subregion, with the result falling 12% shy of the target by the end of 2020. This was due to several barriers and challenges. But important lessons have been learned during the implementation of the WCA HIV catch-up initiative, some of which are outlined in this section.

Determining barriers and overcoming challenges

Several bottlenecks that inhibit access to services required to facilitate the achievement of the 2020 HIV targets were determined in the early implementation stages of the HIV catch-up plan. These were identified via experiences and lessons learned from previous and current attempts to control HIV. These barriers included insufficient involvement of Member State governments, inadequate financial resources, unaffordable user fees, and the widespread stigmatization of PLHIV by communities, including some health care providers.

Others included insufficient decentralization of much-needed services, unsatisfactory optimization of DSD, and repeated stock-outs of essential supplies such as test kits and ART, coupled with little to no access to the most favourable treatment regimens, especially for HIV-infected infants and other children.

However, a number of these barriers were addressed in the initial HIV catch-up plans, and others subsequently. Because most of the barriers determined were associated with the health sector in countries where these plans were being implemented, the catalytic funding provided, including by the WHO, targeted some of these bottlenecks.

5. Barriers, challenges & lessons

Insufficient political commitment at country level resulted in deficient ownership by Member States, but also poor coordination and inadequate domestic funding of the HIV response by countries in the subregion. Other negative factors included weaknesses in health systems, characterized by unsatisfactory health service coverage, especially for geographically inaccessible areas, and lack of technical capacities. Inadequate community involvement across the spectrum of HIV care and treatment, along with ongoing stockouts of HIV-related commodities, has negatively affected performance in several countries. In addition, out-of-pocket expenses for ART, laboratory test kits and hospitalization were obstacles. Some of these were surmounted by Treat All policies and the removal of user fees, which were adopted by all WCA countries.

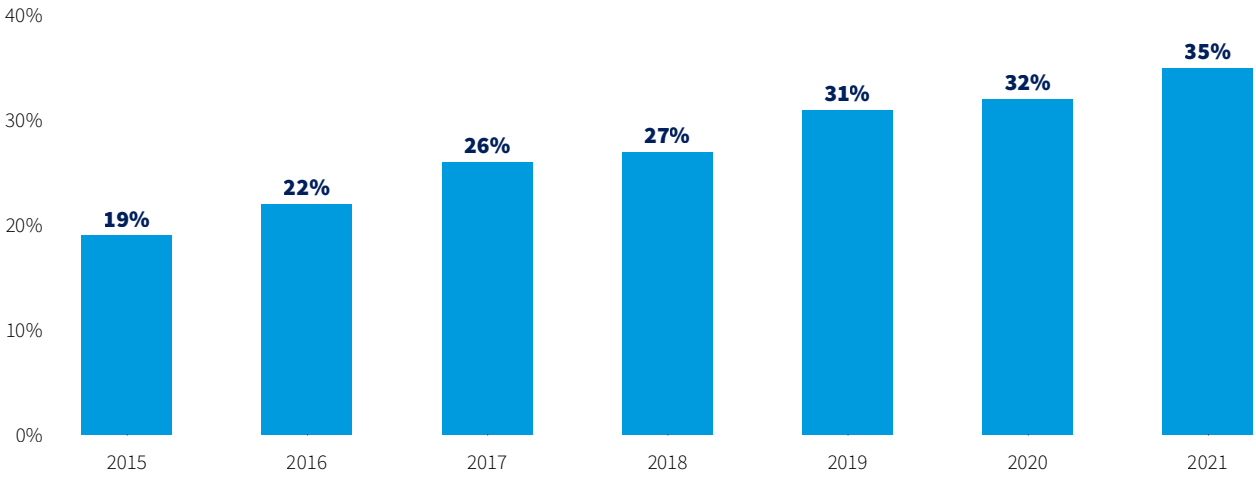
High levels of stigmatization, discrimination and gender inequities combined to reduce access to HIV care and services. Some countries still have punitive laws and policies, coupled with exposure to violence, which has deterred key populations from fully utilizing available HIV health care options. Stigmatization and discrimination against PLHIV have remained high, despite advocacy and health promotion efforts. Weak health systems in some countries posed a further challenge, as did inadequate involvement of community actors. Addressing the remaining challenges will go a long way to facilitating the achievement of the ultimate target to 'end the HIV epidemic as a public health threat by 2030'.

Furthermore, in countries such as Equatorial Guinea, Guinea Bissau, Mali and Sierra Leone, weak health systems, inadequate political commitment and deficient support for community organizations is believed to have delayed desired progress. In Benin, Burundi, Chad, the Congo, Nigeria and The Gambia, HIV-related stigma and in some instances criminalization of certain groups have prevented considerable sections of populations from accessing HIV testing and treatment services. In fact, most of the new HIV infections in WCA over the review period occurred amongst key vulnerable populations and criminalized groups. In addition, countries like Chad, CAR, Cote d'Ivoire, Guinea, Mauritania and The Gambia do not appear to have reliable data to facilitate decision-making, and plan appropriate responses.

5. Barriers, challenges & lessons

Finally, even though there has been progress in WCA among children (0-14 years) living with HIV who are on treatment, there was only a 13% improvement between 2015 and 2020. This was significantly lower than for adults (Figure 5.1). That number improved marginally, to 35%, by 2021, which was still substantially lower than the prescribed target. The main challenge in respect of children in WCA is how to speedily identify those living with HIV, and put them on ART as soon as possible. This would potentially necessitate the expansion of testing of children at birth (infants), and improved adherence to treatment among young adolescents (11-14 years).

Figure 5.1 Shows progress on the percentage of children with HIV on antiretroviral treatment



However, the early identification of children and enrolling them on treatment was, and still is, a huge challenge for all WCA countries. The reasons include the dearth of laboratories with capacities for infant diagnosis, especially in rural areas, with most being in large towns and cities. Some of the supply chain issues have been overcome through improved management and supply of HIV commodities in several countries, but many are still experiencing unrelenting stockouts. This negatively impacts the multi-month dispensing of ART to regular patients in several WCA countries.

Lessons learned

Innovative approaches to increase access and provide services: The DSD service delivery strategy had a huge impact on increasing access to services for PLHIV, especially during the COVID-19 pandemic. Several country-specific defined strategies were tailored, taking local realities into account. Also, adequate support was provided to countries to assist with adjusting their national guidelines. Variations in the DSD approach, adapted during the pandemic, saw the delegation of certain tasks by health personnel to community workers, multi-month ART dispensing to extend the prescription renewal interval for treatment, and remote monitoring of patients. The various adaptations have been very effective in helping reduce the impact of the COVID-19 pandemic on the HIV WCA catch-up initiative between 2019 and 2020 in most countries, excluding Gabon, Guinea and The Gambia.

5. Barriers, challenges & lessons

Effective collaboration and partnership: The design and successful implementation of the various catch-up plans was possible because of strong partnerships between the WHO and other UN agencies, such as UNAIDS and UNICEF, as well as the Global Fund and PEPFAR, to name a few. This collaboration help mobilize additional partners, including technical and financial resources required to support the implementation of the catch-up plan.

Strong WHO leadership, technical assistance and participation: Implementation of the WCA catch-up plan was characterized by strong WHO leadership, with the WHO Regional Director for Africa and WHO Representatives (WRs) in targeted countries committed to coordinate crucial advocacy efforts to boost political buy-in, as well as robust financial support. This was supplemented by the active participation of the Africa Region HIV team and various WHO country office (WCO) teams across WCA, who provided essential technical support. In addition, the WHO recruited additional experts to provide further technical assistance. This not only improved coordination with the WHO technical and financial partners, but also ensured effective joint planning, coordination and monitoring of implementation of the catch-up plans. These experts made technical support at country level more effective by streamlining the process. They also helped harmonize interventions, boosted the sharing of good practices and allocation of resources to address requisite needs, while minimizing duplication of efforts. The catalytic financial resources provided by the WHO, through the Regional Director's Office, were critical to strengthen capacity in WCOs, and was a significant contributor to the progress achieved.

Dogged commitment to keep the goal in focus: The unwavering commitment and strong adherence to the catch-up plan by all partners and national actors, to advance towards the 90-90-90 targets, were among the key factors that facilitated improvements in various WCA countries. The dogged focus also led to the adoption and integration of various interventions into national strategic plans, and requests for funding from the Global Fund.

5. Barriers, challenges & lessons

Accurate data made a huge difference: ART coverage in Nigeria was reported as barely 28% in 2015, but this was based on inaccurate data in a country bearing about half the total WCA HIV burden. To improve evidence towards better planning and decision-making, Nigeria conducted several population surveys and obtained more accurate information that was utilized to revitalize the national treatment programme. Better targeting resulted from the new data, driving remarkable progress towards 65% coverage by the end of 2019. Also, across WCA, new data has demonstrated that certain population groups are largely responsible for increasing numbers of HIV infections. This called for a different focus, given that this has not been observed in the ESA subregion. It resulted in an alternate approach that contributed to the progress recorded.

6 Next steps

6. Next steps

Improve collaboration and communication: The WHO has effectively performed its leadership and coordination role since the start of implementation of the catch-up plans. Strengthening of this role should be encouraged. There is also a need to improve collaboration and communication to support countries, through defined strategies tailored to each country's requirements, and accounting for local realities.

Focus on strengthening health systems and leadership at country level: One of the major issues encountered in several countries were weak health systems. These require strengthening in what appears to be the only way to sustain effective interventions towards the achievement of set and future HIV goals. Several countries need technical support to build capacities in Ministries of Health. Boosting these resources will help identify problems in a holistic manner, to define and tailor intervention strategies, ensure adequate implementation, and monitor for effective response.

Promote innovative ways of achieving set goals: The lessons learned have demonstrated that the DSD approach, with elements such as the delegation of certain tasks by health personnel to community workers, and remote monitoring of patients, among other things, are key drivers of performance in countries, especially for ART coverage. These innovative strategies need to be strengthened and upscaled, along with the upskilling of community workers, for effectiveness. In addition, advocacy for the adoption of integrated services is needed, coupled with capacity-building in communities.

Target key groups that are not currently well-served: Children are one such group, especially infants and early adolescents (11-14 years). Children are being left behind and the issue requires a sharper focus. Children's services should be incorporated into intervention plans like those for pregnant women, where all are tested and screened. Adoption of integrated PMTCT and paediatric ART programmes should be promoted. These would help locate and diagnose more children living with HIV, and see them placed on treatment, to close the HIV treatment gap for children (0-14 years).

6. Next steps

Increase viral load suppression levels: Insufficient data on those who have achieved viral suppression has been a major problem. This requires concerted effort that would increase demand. Placement on treatment is not enough. Those on treatment need to be monitored to ensure attainment of viral suppression.

Promote sharing of lessons and good practices: Documenting lessons and sharing good practices have already been adopted. However, more effort is needed to locate PLHIV. The art of tailoring responses should be promoted as a good practice. This could be informed by, among other things, local data.

Advocate for removal of punitive laws and policies: Effective HIV interventions are those that provide access to the required services for all populations, and not just some. Strong advocacy to remove punitive laws and policies against marginalized populations should be supported. This will create an enabling legal and policy environment, but also reduce stigmatization and discrimination, and help expand intervention coverage.

Incorporate humanitarian context when crafting interventions strategies: Humanitarian and crises impacting countries, such as CAR, should be incorporated when defining and developing HIV interventions. This will ensure the continuity of prevention, treatment and care services in affected countries.

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