

UNDERSTANDING GAPS IN THE HIV CARE CONTINUUM IN 11 WEST AFRICAN COUNTRIES

Findings from ITPC's Regional Community Treatment Observatory

JUNE 2019

The Regional Community Treatment Observatory in West Africa (RCTO-WA) is a consortium project led by the International Treatment Preparedness Coalition (ITPC) and ITPC West Africa. The project works to increase access to optimal HIV treatment in 11 West African countries through the systematic monitoring of services by national networks of people living with HIV. Supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the RCTO-WA collects and analyzes data on **availability, accessibility, acceptability, affordability** and **appropriateness** of HIV care and services. The project has a particular focus on access to, and quality of, HIV services for five priority populations: pregnant women, young people, men who have sex with other men, people who inject drugs and sex workers.

Availability

The RCTO-WA documented the frequency of stock-outs¹ along the cascade at 8.8% for HIV test kits, 23.4% for ARVs and 17.2% for viral load testing supplies (Table 2). Stock-outs of ARVs were most frequently reported in Liberia and Togo (47.4% and 46.7% respectively), and least in Benin (0%) and Ghana (10.3%). On average, stock-outs lasted for 40.5 days. In the most extreme case, one health facility in Côte d'Ivoire reported a tenofovir and lamivudine stock-out lasting **nearly 7 months**. In countries where ARV stock-outs were more frequent, ART initiation rates were lower ($r = -.876$, $p = <.05$).

¹ Stock-outs are defined as reported absence of HIV test kits, ARVs or lab supplies during monthly visits from RCTO-WA data collectors at monitored facilities.

TABLE 1. Characteristics of the RCTO-WA Dataset

QUALITATIVE DATA (July 2017 – June 2018)	
KEY INFORMANT INTERVIEWS	279
FOCUS GROUP DISCUSSIONS	110
QUANTITATIVE DATA (January – June 2018)	
TOTAL # OF COUNTRIES IN THE RCTO-WA	11
Total # of health facilities monitored	103
<ul style="list-style-type: none"> ■ Benin ■ Côte d'Ivoire ■ Gambia ■ Ghana ■ Guinea ■ Guinea-Bissau ■ Liberia ■ Mali ■ Senegal ■ Sierra Leone ■ Togo 	<ul style="list-style-type: none"> 3 19 13 7 13 2 6 5 16 20 11
# OF HIV TESTS PERFORMED AT RCTO-WA FACILITIES	161,607
# OF PEOPLE ON ART AT RCTO-WA FACILITIES	81,817
# OF VIRAL LOAD TESTS PERFORMED AT RCTO-WA FACILITIES	16,491
# OF YOUNG PEOPLE (AGE 15-24 YEARS) REACHED AT RCTO-WA FACILITIES	15,442
<ul style="list-style-type: none"> ■ Male ■ Female 	<ul style="list-style-type: none"> 4,877 10,565
# OF KEY POPULATIONS REACHED AT RCTO-WA FACILITIES	9 357
<ul style="list-style-type: none"> ■ MSM ■ SW ■ PWID 	<ul style="list-style-type: none"> 2,077 6,491 789

TABLE 2. Frequency of Recorded Stock-outs at RCTO-WA Health Facilities (January-June 2018)

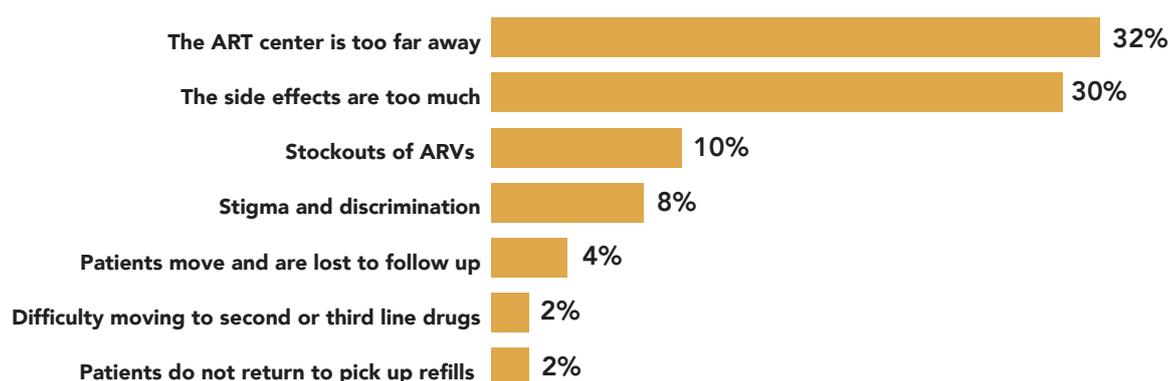
COUNTRY	STOCK-OUTS OF HIV TEST KITS	STOCK-OUTS OF ANTIRETROVIRAL DRUGS	STOCK-OUTS OF VIRAL LOAD LAB SUPPLIES
	Mean % of health facility visits where stock-outs were recorded (95% CI)		
All Countries	8.8 (6.4-11.2)	23.4 (19.8-27.0)	17.2 (14.0-20.4)
Benin	0.0 (0.0-0.0)	0.0 (0.0-0.0)	16.7 (0.0-38.7)
Côte d'Ivoire	2.9 (0.0-6.1)	13.3 (6.8-19.8)	0.0 (0.0-0.0)
Gambia	0.0 (0.0-0.0)	16.2 (7.4-24.9)	50.0 (38.0-62.0)
Ghana	2.6 (0.0-7.7)	10.3 (0.7-19.8)	0.0 (0.0-0.0)
Guinea	45.5 (32.2-58.7)	34.5 (21.9-47.2)	54.5 (41.2-67.8)
Guinea-Bissau	8.3 (0.0-24.7)	16.7 (0.0-38.7)	0.0 (0.0-0.0)
Liberia	5.3 (0.0-12.4)	47.4 (31.3-63.4)	7.9 (0.0-16.5)
Mali	16.7 (0.0-34.0)	22.2 (2.9-41.6)	5.6 (0.0-16.2)
Senegal	12.7 (3.9-21.5)	21.8 (10.9-32.8)	20.0 (9.4-30.6)
Sierra Leone	5.5 (0.8-10.2)	23.1 (14.4-31.7)	5.5 (0.8-10.2)
Togo	0.0 (0.0-0.0)	46.7 (32.0-61.4)	13.3 (3.4-23.3)

Accessibility

Qualitative RCTO-WA data highlight accessibility to HIV testing services (HTS) as a key barrier to uptake.

Among 289 interviews and focus group discussions, more than a third (35%) of all respondents said that long distances to the health centres where HTS is performed is the main reason why people are not accessing this service.

For those who did access HTS, linkage to care and treatment initiation was high at RCTO-WA facilities. Between April and June 2018, 4,692 people tested positive for HIV and 4,354 were initiated onto ART. Treatment initiation rates were lower for MSM (89%; n=85/95), sex workers (78%; n=76/98) and young people (72%; n=300/414). Linkage also varied by country. In Sierra Leone, where test-and-treat only

FIGURE 1. Reasons Given for People Not Receiving ART, July 2017-June 2018 (n=321 interviews/focus group discussions)

began in 2018, 905 people tested positive and 647 were initiated onto ART (71%). In Liberia, where test-and-treat is not yet rolled out for all populations, 1086 people tested positive and 521 were initiated onto treatment (48%).

As with HTS, long distances to health facilities was the top cited reason for not accessing ART (32%), followed by side effects (30%) and ARV stock-outs (10%) (Figure 1).

Acceptability

RCTO-WA data show that more than a third of people consulted in interviews and focus groups rated quality of service provision at the relevant health facility as a figure 3 or less out of a possible 5. Quality of care was rated lowest in Sierra Leone (3.40/5.00) and highest in Mali (5.00/5.00). Quality of care was rated lowest among MSM (3.16/5.00) and highest among sex workers and pregnant women (4.00/5.00). Young women age 15-24 ranked quality of care slightly lower than young men (3.73/5.00 vs. 3.86/5.00).

Affordability

Despite high out-of-pocket expenditure on health in the West Africa region, affordability is not cited as a major barrier to access at RCTO-WA monitored health facilities. Among 334 interviews and in focus group discussions, payment was cited as a barrier

Appropriateness

RCTO-WA data shed light on whether the health services provided are targeted and tailored to key and vulnerable populations most in need. Despite the commitment of countries in the Dakar Declaration to strengthen strategic information on key populations, just 38 out of 103 (37%) RCTO-WA facilities report data for at least one key population.

Sixteen percent of all people who tested HIV-positive at these RCTO-WA facilities between April and June 2018 were MSM, sex workers, PWID and young people age 15-24, yet, by June 2018, these groups made up just 7% of PLHIV on ART at the same facilities (Figure 2). These data highlight a disproportionate barrier to accessing treatment for key and vulnerable populations living with HIV. Sub-analyses of RCTO-WA qualitative data show that key and vulnerable populations face different barriers to access than the general population. Among 13 focus group discussions with young

Once initiated onto ART, RCTO-WA data highlight a stark gap in access to viral load testing. Among 81,817 people on ART at RCTO-WA facilities, just 16,491 viral load tests were performed in the six-month period.² Of these, less than half (48%; n=7,960) were virally suppressed (<1000 copies/ml).

The facility, as said, is doing fine after the invention of ITPC. They said the MSM are given good attention after one of their members is working at the facility. That gave them hope because he helps them to get their services.

— Respondent ranked service quality a “5”,
Gambia.

among 2% of respondents for HIV testing services, 5% for ART, and 3% for viral load testing services. This is a perplexing finding, which the RCTO-WA will explore further during focus group discussions in year two of data collection.

For me, a test requires a payment and it is very expensive if you want to know the information on your viral load. The doctor says ‘soon there is failure or lack of reagent’ [to justify charging].

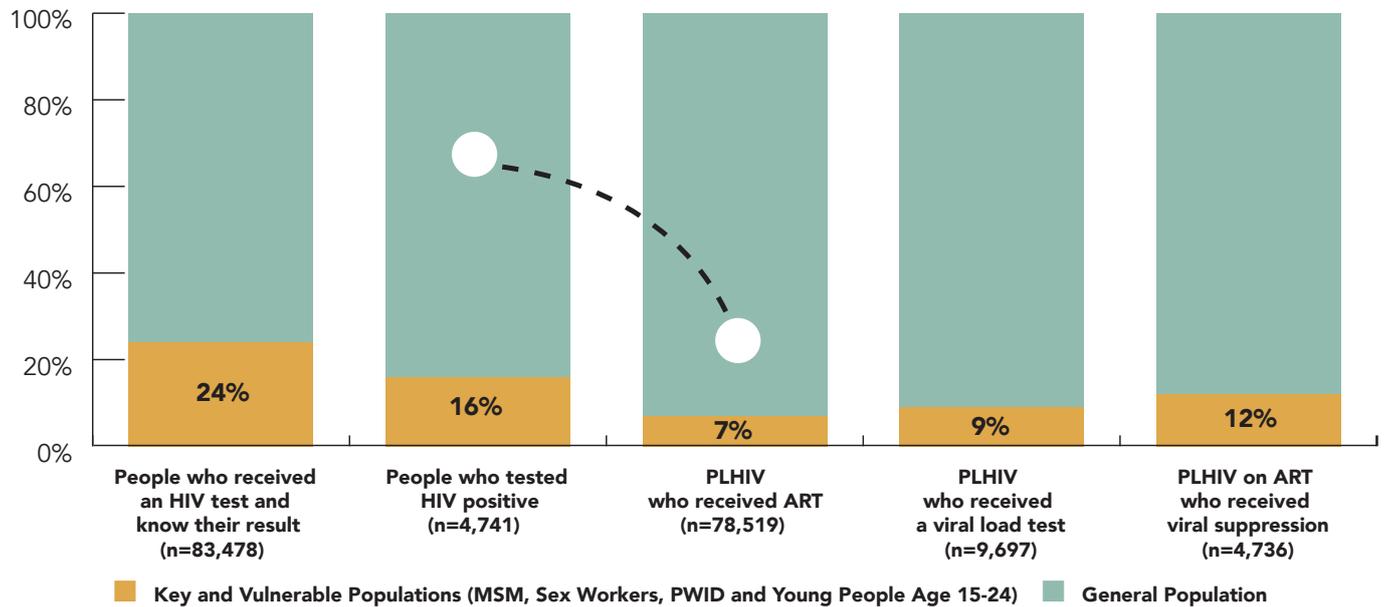
— Midwives PTME focal point,
Mali, CHU GT Health Center

² While the RCTO-WA does not have data on when specific individuals began ART, these figures make it unlikely that the World Health Organization (WHO) recommendation of one viral load test every twelve months for stable patients is being met.

people, issues of confidentiality and privacy emerged as a top reason for not accessing ART. Among 19 focus group discussions held with MSM,

sex workers and PWID, fear of stigma and discrimination emerged as a key reason.

FIGURE 2. Key and Vulnerable Populations Reached Along the Cascade, as a Proportion of All People Reached at RCTO-WA Health Facilities (April-June 2018)



Advocacy Opportunities

By 2020, 90% of people living with HIV will know their status

- Expand the availability of non-facility-based HTS, including community-led and community-based HTS.
- Intensify HIV communication and awareness campaigns to increase demand for HTS.
- Include costed activities to promote and protect human rights of PLHIV and key populations in national plans.

By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy

- Improve communication along the supply chain to prevent antiretroviral stock-outs.
- Enhance linkage to—and retention in—care and treatment, especially for key and vulnerable populations.
- Strengthen community systems and responses to support the roll out of differentiated service delivery (DSD).

By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression

- Increase funding to ensure the availability of adequate viral load testing machines and laboratory supplies.
- Enhance knowledge among PLHIV and healthcare workers to increase demand for viral load testing services.
- Ensure effective treatment monitoring through acceptable turn-around times for viral load test results.

For more information, download our full Advocacy Paper: *Data For A Difference*. In this report we share key findings, analysis and advocacy opportunities emanating from the first 18 months implementing the Regional Community Treatment Observatory across 11 countries in West Africa (RCTO-WA).