

“THEY KEEP US ON OUR TOES”

How the Regional Community Treatment Observatory in West Africa improved HIV service delivery, strengthened systems for health, and institutionalized community-led monitoring



September 2020



ABOUT ITPC

The International Treatment Preparedness Coalition (ITPC) is a global network of people living with HIV and community activists working to achieve universal access to optimal HIV treatment for those in need. Formed in 2003, ITPC actively advocates for treatment access across the globe through the focus of three strategic pillars:

- Treatment education and demand creation (#TreatPeopleRight)
- Intellectual property and access to medicines (#MakeMedicinesAffordable)
- Community monitoring and accountability (#WatchWhatMatters)

To learn more about ITPC and our work, visit itpcglobal.org.

ABOUT WATCH WHAT MATTERS

Watch What Matters is a community monitoring and research initiative to gather data on access and quality of HIV treatment globally. It defines a core strategic objective of ITPC to ensure that those in power remain accountable to the communities they serve.

Monitoring of health systems by communities increases government accountability and informs targeted advocacy actions that can improve HIV treatment, particularly for marginalized populations. Over the last decade, ITPC has been monitoring the scale-up and quality of HIV treatment in different countries around the world from a community perspective. In South Asia, Eastern Europe and Central Asia, ITPC has monitored supply chain management issues and drug stock outs. In 2015, with the support of Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), community treatment observatories (CTOs) were formalized in East Africa, West Africa, Central Africa and Latin America.

Building on this work, *Watch What Matters* aims to streamline and standardize treatment access data collected by communities – helping ensure that data is no longer collected in a fragmented way and better integrates questions and themes most important to those affected by HIV. It relies on a unique model that empowers communities to systematically and routinely collect and analyze

qualitative and quantitative data on barriers to access. Data generated guides advocacy efforts and promotes accountability.

Currently, *Watch What Matters* is implementing a number of projects, including the Regional Community Treatment Observatory in West Africa, the Missing the Target report series, and community treatment observatory initiative in Malawi, Zimbabwe and Zambia.

To learn more about *Watch What Matters* and our work, visit www.WatchWhatMatters.org

ABOUT THIS PUBLICATION

In this publication, we share three big stories of community-driven change. Looking back over two years of data collection and capacity strengthening, we reflect on how the Regional Community Treatment Observatory in West Africa: (1) Improved HIV service delivery, (2) Strengthened systems for health, and (3) Institutionalized community-led monitoring.

FOR MORE INFORMATION

Please contact us at admin@itpcglobal.org

ACKNOWLEDGEMENTS

ITPC thanks and acknowledges those who have supported our work in this critical area of community-led monitoring. In particular, we recognize the tireless efforts of our partners in the Regional Community Treatment Observatory in West Africa project who implemented this work, including the eleven national networks of people living with HIV, members of the national community consultative groups (CCGs), the members of the Regional Advisory Board (RAB), and PAC-CI (Programme Agence Nationale de Recherche sur le Sida Coopération **Côte d'Ivoire**).

ITPC also acknowledges support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the 5% Initiative, The Robert Carr Fund, Aidsfonds - Bridging the Gaps, Open Society Foundation, and the International AIDS Society.

Dr. Gemma M. Oberth, Independent Consultant, is the lead author of this report. ITPC would like to thank the external reviewers for their feedback and comments on earlier drafts.

CONTENTS

- 1** INTRODUCTION
- 2** OVERVIEW
- 3** PART I
How We Improved HIV Service Delivery
- 7** PART II
How We Strengthened Systems for Health
- 12** PART III
How We Institutionalized Community-led Monitoring
- 15** CONCLUSION
- 17** ANNEXES
 - Country Results Profiles
 - Côte d'Ivoire
 - Ghana
 - Mali
 - Sierra Leone
 - Togo

ABBREVIATIONS

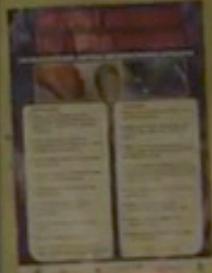
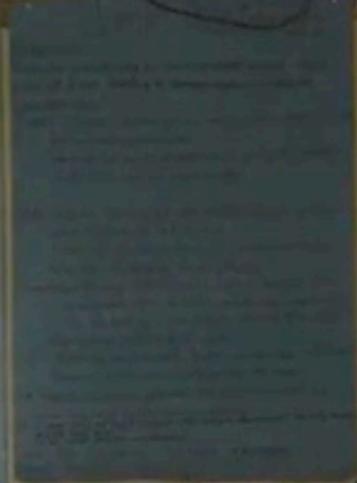
AIDS	. . . . .	Acquired Immune Deficiency Syndrome
ART	. . . . .	Antiretroviral therapy
ARV	. . . . .	Antiretroviral
CCG	. . . . .	Community Consultative Group
CCM	. . . . .	Country Coordinating Mechanism
CeRADIS	. . . . .	Centre de Réflexions et d'Actions pour le Développement Intégré et la Solidarité
CNLS	. . . . .	Conseil National de Lutte contre le SIDA
CNLS-TP	. . . . .	Conseil national de Lutte contre le VIH/Sida, la Tuberculose, le Paludisme, les Infections sexuellement transmissibles et les épidémies
COP	. . . . .	Country Operational Plan
CROI	. . . . .	The annual Conference on Retroviruses and Opportunistic Infections
CTO	. . . . .	Community treatment observatory
DSD	. . . . .	Differentiated service delivery
FMG	. . . . .	Fraternité Médicale Guinée
GIZ	. . . . .	Deutsche Gesellschaft für Internationale Zusammenarbeit
GKPUIS	. . . . .	Ghana Key Population Unique Identification System
HIV	. . . . .	Human Immunodeficiency Virus
IAS	. . . . .	International AIDS Society
ICASA	. . . . .	International Conference on AIDS and Sexually Transmitted Infections in Africa
ITPC	. . . . .	International Treatment Preparedness Coalition
ITPC-WA	. . . . .	International Treatment Preparedness Coalition West Africa
LibNeP+	. . . . .	The Liberia Network of Persons Living with HIV
LINKAGES	. . . . .	Linkages Across the Continuum of HIV Services for Key Populations Affected by HIV
M&E	. . . . .	Monitoring and Evaluation
NAP+	. . . . .	National Network of Persons Living with HIV in Ghana

NETHIPS	Network of HIV Positives in Sierra Leone
PAC-CI	Programme Agence nationale de recherche sur le sida Coopération Côte d'Ivoire
PEP	Post-exposure prophylaxis
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PNLS	Programme National de Lutte contre le SIDA au Togo
PrEP	Pre-exposure prophylaxis
PSNIE	Plan Stratégique National Intégré Pour le Vih/Sida, la Tuberculose, le Paludisme, les Hépatites, les Ist et les épidémies
PSLS	Programme Santé de Lutte contre le Sida
RAS+	Réseau des Associations de Personnes Vivant Avec le VIH au Togo
REBAP+	Réseau Béninois des Associations de Personnes vivant avec le VIH
RIP+	Réseau Ivoirien des organisations de Personnes vivant avec le VIH/SIDA
RMAP+	Réseau Malien des Associations de Personnes vivant avec le VIH
RNP+	Réseau national des associations de personnes vivant avec le VIH au Senegal
SE/HCNLS	Secrétariat Exécutif du Haut Conseil National de Lutte contre le Sida
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

SIMBOTT



CONSULTATION ROOM



INTRODUCTION

In West and Central Africa, 64% of people living with HIV are aware of their status, 51% are accessing antiretroviral therapy (ART), and 39% are virally suppressed. Progress is stymied by low demand for services, stock-outs, weak health systems and poor quality of care.

In 2017, the International Treatment Preparedness Coalition (ITPC) established a Regional Community Treatment Observatory in West Africa to increase accountability for the 90-90-90 targets (by 2020, 90% of all people living with HIV know their HIV status, 90% of those receive sustained ART, and 90% of people receiving ART have viral suppression). The Regional Community Treatment Observatory in West Africa is a consortium led by ITPC and ITPC West Africa, supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Through the systematic monitoring of services by national networks of people living with HIV, the project works to increase access to optimal HIV treatment in 11 West African countries: **Benin, Côte d'Ivoire, Gambia, Ghana, Guinea-Conakry, Guinea-Bissau,* Liberia,**

Mali, Senegal, Sierra Leone and Togo. The Regional Community Treatment Observatory in West Africa collected and analyzed qualitative and qualitative data on the availability, accessibility, acceptability, affordability and appropriatedness of HIV services. The project had a particular focus on assessing access to, and quality of, HIV services for pregnant women, young people, men who have sex with men, people who inject drugs and sex workers.

From January 2018 to June 2019, the Regional Community Treatment Observatory in West Africa completed 1781 monthly monitoring reports at 125 health facilities across the 11 countries. Giving nuance and depth to the quantitative data, 1501 interviews and 143 focus group discussions were held with recipients of care and healthcare workers. Regular feedback was provided to stimulate engagement with the data, create demand for services, and encourage quality improvements. This fostered a culture of collective problem-solving among healthcare providers, decision-makers, and recipients of care.

*Data collection in Guinea-Bissau ended after Period 1 (January-June 2018).

BOX The Power of Big Data in the Hands of Activated Communities

	11 COUNTRIES		105,435 PEOPLE ON ART[‡]
	2 YEARS OF MONITORING		81,380 VIRAL TESTS PERFORMED
	84 DATA COLLECTORS		1501 INTERVIEWS
	125 HEALTH FACILITIES		143 FOCUS GROUPS
	1781 QUANTITATIVE REPORTS		98,651 YOUNG PEOPLE REACHED
	631,863 HIV TESTS PERFORMED		35,577 KEY POPULATIONS REACHED

[‡]A statistically significant sample size for the entire West and Central African region (95% confidence interval)

OVERVIEW

In this paper, we share three big stories of community-driven change.

Looking back over three years of project implementation, we reflect on how the Regional Community Treatment Observatory in West Africa: (1) Improved HIV service delivery, (2) Strengthened systems for health, and (3) Institutionalized community-led monitoring.

Previous publications provide more detail on ITPC's community treatment observatory model, the data we collected, and the advocacy agenda we furthered (See [Resources](#)). Here, we focus on the bigger-picture results we achieved, and how we got there.

We hope these stories propel further scale-up of community-led monitoring initiatives around the world.

“ All too often, activism pits ‘us’ versus ‘them,’ but our Community Treatment Observatory Model fosters a culture of collective problem-solving among health-care workers, decision-makers and recipients of care. The beauty of this process is that we changed the way people living with HIV were perceived. Clinics were now calling on community data collectors for help with monitoring. What started out as a regional project in 11 West African countries has become a model for community-based monitoring anywhere in the world. ”

SOLANGE BAPTISTE

Executive Director, ITPC Global

PART 1

How We Improved HIV Service Delivery

The Regional Community Treatment Observatory in West Africa was born out of sheer necessity. People living with HIV were fed up with frequent stock-outs of medicines and commodities (e.g. reagents and consumables). They took pen to paper, and began to document these violations and compel action within their local area. Through ITPC's project, these ad hoc 'alerts' were transformed into a systematic approach.



“ They keep us on our toes. Toes, in the sense that they've been putting pressure on us. Whenever there are stock-outs, they give us the alert. Then, we assemble our partners to help us to quickly distribute the drugs. ”

— Abdul Rahman Sesay, Director General,
National AIDS Secretariat
SIERRA LEONE

We began hearing stories of positive change. At the Bethesda Hospital in Cotonou, **Benin**, after 10 months without viral load reagents, the treatment observatory confronted the

Deputy Coordinator of The National AIDS Control Program with the data, and a solution was quickly found. In **Ghana**, after noticing a trend in stock-outs of pediatric treatment formulations, the observatory mobilized partners to visit the Tamale Regional Medical Stores and the Regional Health Directorate on ART shortages, to identify and resolve the issue at its source. In **Côte d'Ivoire**, stock-outs took an average of 23 days to resolve at the end of the project, compared to 33 days at the mid-point, and 53 at the beginning.

What's more, the size of our dataset gives us confidence that these changes are more than anecdotal. That's the value add of the regional approach. Across all 125 health centers we monitored, in all 11 countries, the frequency of recorded stock-outs steadily declined over the course of the project (Fig 1-2) and access to treatment and care increased (Fig 3-4).

The model also helped expand the monitoring beyond stock-outs. By integrating additional questions and themes that are most important to those affected by HIV, we also routinely collected and analyzed qualitative and quantitative data on other issues, such as barriers to access and quality of care.

Key populations rated quality of care consistently lower than the general population.

During interviews and focus group discussions, the treatment observatory asked recipients of care to rate the quality of services they received, 1 being the lowest and 5 being the highest. Our data reveal that as services became more available and accessible, the

quality of care also improved (Fig 5). Sub-analyses of this indicator for key populations reveals a similar upward trend, though key populations rated quality of care consistently lower than the general population.

Viral load suppression is another important quality of care indicator, often reflecting good adherence to uninterrupted ART and effective treatment monitoring. Here, our data points to remarkable progress. In the first six months, an average of 48.4% of people on ART at RCTO-monitored sites were virally suppressed (<1000 copies/mL). This rose to 67.9% at the mid-point, and 77.4% at the end of the project (Fig 6). We believe this dramatic change reflects a culmination of treatment observatory effects, including reducing ART stock-outs, increasing access to viral load testing, improving treatment literacy among recipients of care, and reducing turn-around time of viral load test results.

An important insight from the treatment observatory's qualitative data, is the magnitude of stigma and discrimination as a barrier to accessing services. In the first six month of implementation, 16% of people we spoke to at the monitored health facilities said that fear of stigma and discrimination was the reason people were not coming for HIV testing services. This fell to 11% by the end of the project. Reducing stigma and discrimination among key populations was a significant focus of the community treatment observatories. In **Ghana**, the treatment observatory paid visits to Imams, women's groups and Chiefs in Tamale, using their data to open a dialogue about HIV and key populations.

The data collection process itself helped remove barriers to access for key populations. Across the 11 countries, 20 men who have sex with men, 15 sex workers and 2 people who inject drugs were active members of the treatment observatory data collection teams. In **The Gambia**, by virtue of having key populations on the data collection teams, their peers felt emboldened to come for services. The visibility of key populations in the health facility as part of the treatment

observatory helped reduce fear among the wider community. During interviews and focus group discussions at the Fraternité Médicale Guinée (FMG) in **Guinea-Conakry**, – a health center geared towards key populations and young people – data collectors also took the opportunity to share information with key populations about their rights and what kinds of HIV services they should seek. In **Ghana**, the treatment observatory used focus group discussions as a way to engage key populations and refer them to key population-friendly health centres. In addition, the process of doing interviews and focus groups with health care workers helped to sensitize them about the importance of providing key population-friendly health services.

Our data show that the treatment observatory model worked to educate and engage communities, increasing demand for HIV services. The number of people on ART at RCTO-monitored health facilities rose from 81,817 in the first six months, to 90,008 in the second and 105,435 in the third. Demand for viral load testing more than doubled, from 16,532 tests in the first six months to 33,376 in the last six months.

There was significant demand created for HIV services as a result of our community treatment observatory model. For example, the number of viral load tests performed at our monitored health facilities more than doubled during the project.

The increased demand for services among key populations was particularly striking. In the RCTO-WA sample, 16 health facilities in 8 countries (**Benin, Côte d'Ivoire, Ghana,**

Key Improvements at Our Monitored Sites

Availability

Figure 1. Frequency of Recorded **ART Stock-outs** at RCTO-Monitored Facilities

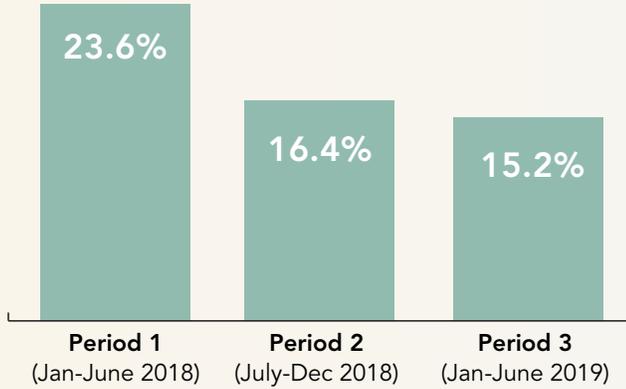
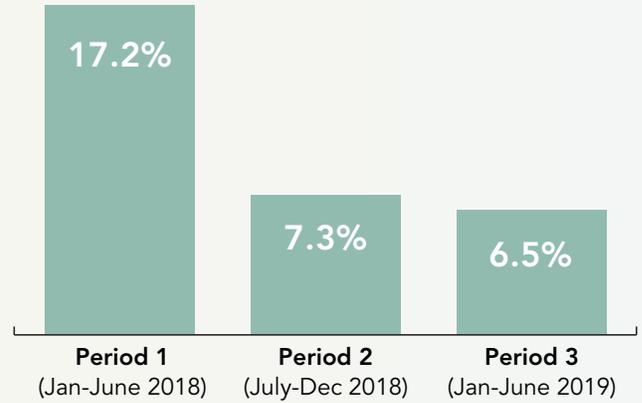


Figure 2. Frequency of Recorded **Viral Load Lab Stock-outs** at RCTO-Monitored Facilities



Accessibility

Figure 3. Number of **People on ART** at RCTO-Monitored Health Facilities

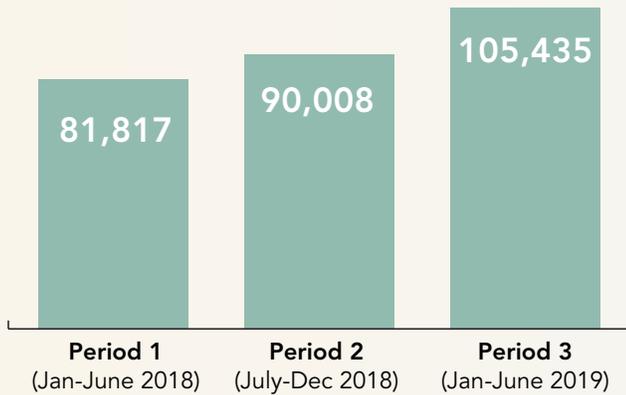
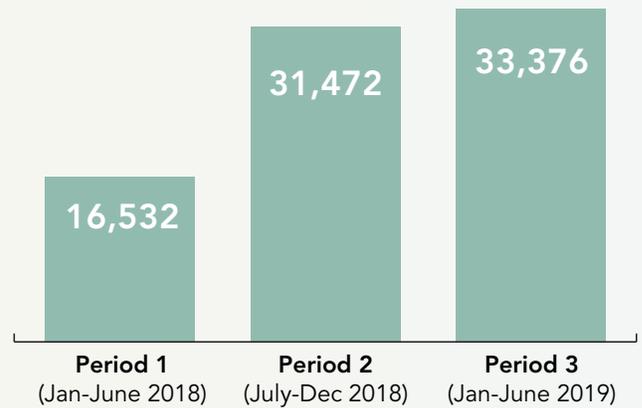


Figure 4. **Viral Load Tests** Performed at RCTO-Monitored Health Facilities



Acceptability

Figure 5. Average **Quality of Care** Rating (out of 5) at RCTO-Monitored Health Facilities

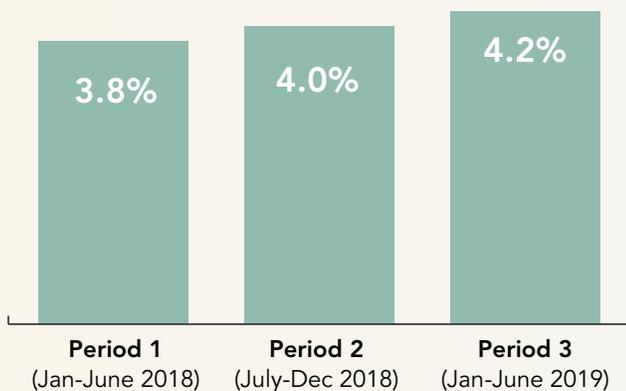
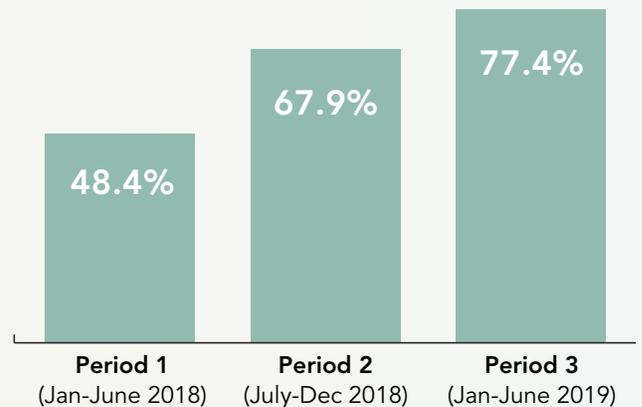


Figure 6. Rate of **Viral Load Suppression** at RCTO-Monitored Health Facilities



Guinea-Conakry, Mali, Senegal, Sierra Leone and Togo) provided health services to key populations. At these sites, the number of new treatment initiations among men who have sex with men, sex workers, and people who inject drugs across all RCTO-monitored sites rose from 63 in the first six-month period of the project, to 420 in the second, to 1106 in the third – a 17-fold increase. In **Senegal**, the community treatment observatory helped to create reference centers for key populations in each region, contributing to this increased demand for services. In **Liberia**, the treatment observatory worked closely with the LINKAGES project to refer key populations for services. In

Ghana, collaboration with USAID's Strengthening the Care Continuum project helped the treatment observatory link men who have sex with men and female sex workers to friendly services.

Over the course of the project, the number of new ART initiations among key populations increased more than 17-fold at RCTO monitored sites.



PART II

How We Strengthened Systems for Health

At its core, the Regional Community Treatment Observatory in West Africa aimed to strengthen systems for health. Through our monitoring, we have contributed to better health sector governance and planning, upgraded laboratory systems, improved health management information systems and M&E, and stronger community systems. Here is how we did it.

The most common reason given for not accessing HIV testing services was the long distance to the testing center.

The data collected by the treatment observatories consistently pointed out policy barriers. After the first year of qualitative data collection, the most common reason given for not accessing HIV testing services was the long distance to the testing center. This was mentioned by more than a third (35%) of people. Despite the World Health Organization (WHO) guidelines on non-facility-based testing options – such as HIV self-testing and community-based testing – few countries had policies in place to roll them out. As of July 2019, **Nigeria** was the only West African country with an HIV self-testing policy that was implemented. HIV self-testing policies are still in development in **Gambia, Ghana, Liberia, Sierra Leone** and **Togo**. In **Benin, Cote d'Ivoire, Guinea-Conakry, Guinea-Bissau, Mali** and **Senegal**, an HIV self-testing policy existed, but was not being implemented.

Pushing governments to develop policies on differentiated service delivery (DSD) became a major part of our advocacy agenda. In

Ghana and **Sierra Leone**, the observatories focused their advocacy on the need for differentiated HIV services for key populations. In December 2017, **Ghana** launched an operational manual for differentiated service delivery which spelled out a shift from mass general population testing to targeted population testing, including provider-initiated testing for key populations and high-risk men. In March 2019 – after sustained advocacy from the treatment observatory – **Sierra Leone** launched its policy on differentiated service delivery. This policy includes community-based testing options for key populations, coupled with peer navigation to increase linkage to prevention and treatment services. In February 2019, **Mali** also launched a differentiated service delivery strategy, which also moves from a generalized to a focused approach for HIV testing, prioritizing key populations and self-testing options.

Once new policies were adopted, the community treatment observatories used their data to push for effective implementation. **Ghana's** differentiated service delivery operational manual estimates that targeted HIV testing among key populations could reduce costs by about \$1 million while also increasing HIV-positive yield. The treatment observatories provided regular feedback to health facilities about the numbers of key populations tested, to ensure new policies were implemented with fidelity. Our data suggest that these advocacy efforts were effective. At RCTO-monitored health facilities, HIV testing has indeed become more targeted to those at higher risk. At a regional level, the number of HIV tests performed at our monitored sites went down, but the HIV-positive yield went up (Fig 7-8).

The community treatment observatories provided regular feedback to health facilities about the numbers of key populations tested, to ensure new policies were implemented with fidelity.

Recipients of care confirmed to us that differentiated service delivery was being offered. In the first year of data collection, 35% of people we interviewed said that the long distance to the HIV testing center was the main reason they did not receive a test. In the second year, just 8% said that distance to health facilities was a challenge. There has been a large expansion of community-based HIV testing in **The Gambia** and **Sierra Leone**, especially for key populations, as a result of our advocacy for differentiated service delivery.

Our advocacy contributed to the development of differentiated service delivery policies in Ghana, Mali and Sierra Leone. We then ensured that these policies were implemented at our monitored sites.

The removal of user-fees for HIV services was another important policy change we helped to achieve. During interviews and focus group discussions, 17% of the recipients of care we spoke to said that payment or considerable out-of-pocket expenditure was a reason for not accessing ART. Even if the antiretroviral medicines were available for free, fees for diagnostic tests, consultations with healthcare providers, and medicines for opportunistic infections were having a huge negative impact on recipients of care.

“ The majority of people living with HIV were coming from disadvantaged communities, and couldn't afford to pay the fees for on-site treatment. The Observatory pressured the Ministry of Health to sign a by-law stating that from now on, on-site treatment wouldn't be charged. This was a major aspect of our intervention. ”

— Valentin Keipo,
Community Treatment Observatory Focal Point
CÔTE D'IVOIRE

The treatment observatory in **Côte d'Ivoire** used their data to advocate for free HIV services. This advocacy was successful. In April 2019, a note was circulated by the Ministry of Health which signaled its commitment to stop people being charged for accessing HIV testing and treatment services, declaring that it will strictly apply previously announced decisions to prevent people living with HIV being asked to pay user fees.

Strengthening laboratory systems was another key priority for the Regional Community Treatment Observatory in West Africa. Our data showed that there was limited access to viral load testing in the region. As of December 2018, RCTO-monitored facilities had 90,008 people on ART and performed 48,004 viral load tests in the past year (January-December 2018), for an estimated coverage of 53.3%. The WHO recommends that all stable patients should receive a viral load test every 12 months.

Advocacy for increased funding to ensure the availability of adequate viral load testing machines and laboratory supplies was a core tenet of our advocacy plan. In **The Gambia**, there was just one viral load machine in the whole country in 2017 (at the beginning of the RCTO-WA project). The treatment observatory

engaged decision-makers with their data, advocating for more machines to increase access to viral load testing services. At the end of the project, there are now seven viral load machines in **The Gambia**, vastly improving treatment monitoring for recipients of care.

Inadequate sample transportation systems were also identified as a major factor contributing to delays in getting viral load test results back from the lab. When we asked recipients of care and health service provider why people were not accessing viral load testing, 38% said it was because viral load results are unavailable or take too long to come back from the lab. Our data also showed that faster turnaround times for viral load test results were associated with improved rates of viral suppression ($r=.66, p<.05$).

In **Mali**, the treatment observatory held an advocacy day on 26 July 2019 at the Ministry of Health and Social Action, under the following theme: *“The delay in reporting viral load results is a major problem. Accelerate results at the laboratory level”*. At the end of the advocacy day, the national AIDS council (SE/HCNLS) agreed to a tri-partite contract with the Malian network of people living with HIV (RMAP+) to accelerate the provision of viral load services. As part of this contract, RMAP+ is now an active partner working with government to improve viral load services. In August 2019, the SE/HCLNS equipped RMAP+ with nine motorcycles (four in Bamako and five in the other regions) to facilitate faster transport and transmission of lab samples and viral load results. In **Ghana**, the treatment observatory performed similar advocacy for faster turnaround time of viral load results. A contract was signed with the **Ghana Post** to help get viral load results back from the laboratory sooner. As a result of these efforts, our data show that over the course of the project, viral load test results were returned to recipients of care sooner (Fig 9-10).

The Regional Community Treatment Observatory also contributed to improved

health management information systems and M&E. Our data collectors worked with health facility staff to ensure that facility data was accurate and that it was used to inform decision-making. At the Sylvanus Olympio University Teaching Hospital in Lomé, **Togo**, the service supervisor in the prevention of mother-to-child transmission unit used data collected by the treatment observatory to cross-checks information in its central reporting system. At the Gabriel Touré University Teaching Hospital in Bamako, **Mali**, our data collectors pointed out to the health facility managers that viral load test results were being transferred from patient registers to the central viral load databases in groups, clustered by date. This compromises patient monitoring. The action of the treatment observatory triggered a change in facility practice. Now, the information is transferred by individual patient. At the Tombo Community Health Centre and the Princess Christian Maternity Hospital in **Sierra Leone**, health facility staff relied on RCTO data collectors to support them with daily tasks, demonstrating the trust between facilities and communities as well as improved capacity.

Critically, the RCTO model captures the user experience, which all too often is missed by routine health information systems. Our qualitative data provides vital insights into the enabling and inhibiting factors for better HIV care in the region. Improved quality of care ratings at RCTO-monitored facilities (recall Fig 5) demonstrate this.

The RCTO model captures the user experience. All too often, this is missed by routine health information systems.

Finally, the Regional Community Treatment Observatory in West Africa strengthened community systems by improving the overall capacity, resiliency and sustainability of networks of people living with HIV. The eleven

Effects of our Advocacy for DSD

More Targeted HIV Testing

Figure 7. Number of **HIV Tests** Performed at RCTO-Monitored Facilities

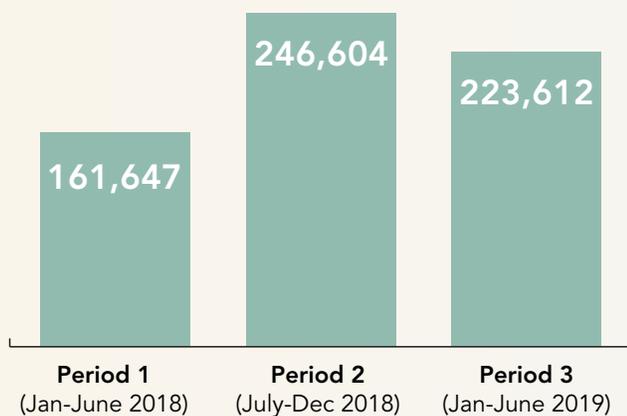
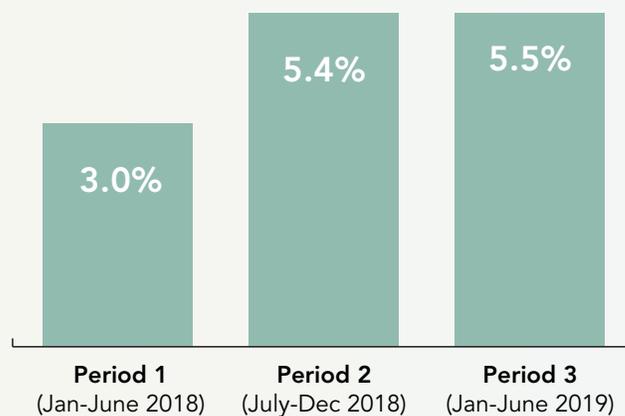


Figure 8. **HIV-positive Yield** from HIV Tests Performed at RCTO-Monitored Facilities



Faster Turnaround Time

Figure 9. People Who Got Their **Viral Load Result Within 2 Weeks** at RCTO-Monitored Facilities

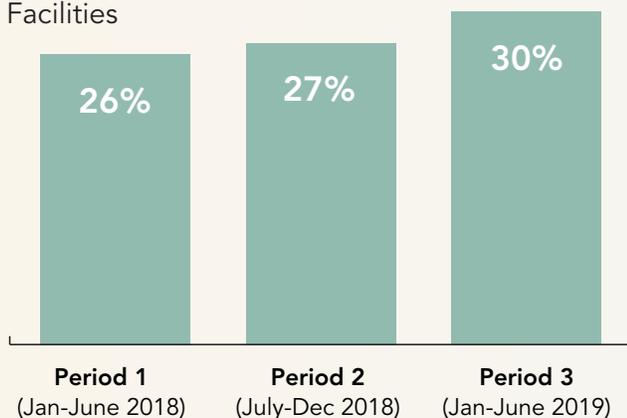
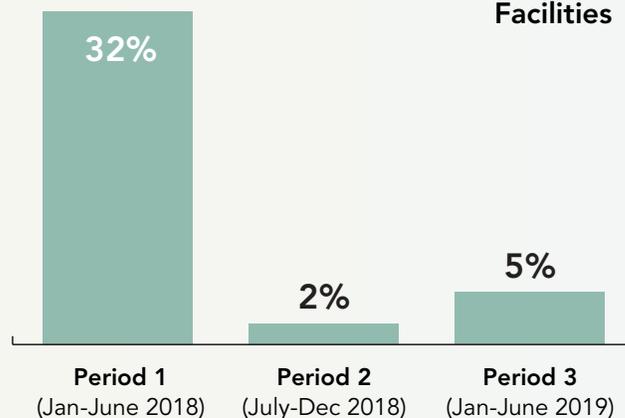


Figure 10. People Whose **Viral Load Results** Took More than 3 Months at RCTO-Monitored Facilities



national networks of people living with HIV received intensive technical and financial training from ITPC, coupled with ongoing mentorship during project implementation. This capacity building worked to increase the profile of national networks, not only with health facilities, but also at higher levels.

In **Liberia**, the national network of people living with HIV (LibNeP+) has benefited from improved visibility in the national response as a result of the project. Now with a stronger reputation, the network is working with the

World Health Organization and the National AIDS Council to provide peer navigation for people who test positive for HIV, linking them to care and treatment at facilities.

In **Senegal**, the project increased recognition of the national network's (RNP+) "Watch and Warning Tool", including its role in strengthening the national HIV response.

In **Togo**, the project improved the ability of the national network of people living with HIV (RAS+) to do evidence-based advocacy,

making them more credible. RAS+ backed up their interventions with data during CCM meetings, meetings of the Quantifying Committee of Inputs, and meetings with civil society, CNLS/PNLS and USAID.

There are also several examples of how the project worked to boost the sustainable financing of networks of people living with HIV. In **Côte d'Ivoire**, the treatment observatory presented their data at the American embassy in Abidjan. This garnered them an invitation to present their findings at the PEPFAR Country Operational Plan (COP) Review meetings in Johannesburg in February 2019. Here, they caught the eye of Ambassador Deborah Birx, who praised the model and insisted it be funded. The national network of people living with HIV (RIP+) has now secured funding to continue its treatment observatory work during COP19 (October 2019 – September 2020). Additional funding was secured from the World Bank to enable RIP+ to expand its community-led monitoring work and apply it to broader contexts.

Through the project, networks of people living with HIV were able to mobilize additional funds from WHO, the World Bank, Solthis, Christian Aid and PEPFAR.

RAS+ in **Togo** also received funding from PEPFAR/Health Policy Project (HP+) to continue its community treatment observatory work in COP 19.

The Network of HIV Positives in **Sierra Leone** (NETHIPS) used data collected through the treatment observatory to mobilize additional funds from Christian Aid for livelihood activities to support people's out-of-pocket expenditure on HIV services. During implementation of the project, NETHIPS also identified training needs for its members. It shared these needs during review meetings at Sia Nyama Vocational Training Center, leveraging funds from other partners. Solthis is now supporting NETHIPS to build skills in advocacy and proposal development.

“ The Regional Community Treatment Observatory improved our evidence-based advocacy.

We are more credible.

We are relied on. ”

— Amen Hlomewoo,
Community Treatment Observatory Focal Point
TOGO



PART III

How We Institutionalized Community-led Monitoring

The Regional Community Treatment Observatory in West Africa is having a ripple effect, beyond the three-year project. By stimulating systemic changes, there will be lasting impact in the region. This work solidified relationships among national networks of people living with HIV, health facilities, high-level decision-makers, and recipients of care. The project developed and tested a replicable approach. What started out as a small regional project in West Africa has become a model for community-led monitoring anywhere in the world.

The formation of the Community Consultative Groups (CCGs) are a key way in which the project institutionalized community-led monitoring. The CCGs are in-country technical advisory boards, which meet on a quarterly basis to review the data from the community treatment observatory and prioritize advocacy actions. They are multi-stakeholder in nature and are typically chaired by high-level national decision-makers (Fig 11). For instance, in **Benin**, the Chair of the CCG sits within the Office of the President. In some places, CCGs have proven sustainable. Now with support from PEPFAR, the treatment observatory in **Côte d'Ivoire** is maintaining its CCG, expanding the membership from 12 to 25. In **Sierra Leone**, CCG members expressed the intention to include their activities in the next Global Fund grant.

The project helped cultivate high-level political will and domestic buy-in for community-led monitoring. In **Côte d'Ivoire**, our work was presented to the Director General for Health, who said he wished to see the model expanded to all districts in the country. In **Benin**, the Director General for Health and the National AIDS Council (PNLS) gave testimony that the community treatment observatory

moved them to improve performance, by identifying quantification issues as the main reason for stock-outs.

This political will often translated into formal agreements between governments and national networks of people living with HIV. These agreements were context-specific and had different parameters depending on the country. For example, in Senegal, the project led to the establishment of a consultative framework between the national network of people living with HIV (RNP+) and the National AIDS Council (CNLS) to prevent stock-outs of medicines. In **Mali**, advocacy through the project led to the signing of a tri-partite contract between the national AIDS council (SE/HCNLS) and the national network of people living with HIV (RMAP+), to accelerate the provision of viral load services. In **Liberia**, the treatment observatory continuously engaged the National AIDS Council, UNAIDS and Global Fund Country Coordinating Mechanism (by joining oversight meetings), notifying them about every stock-out. As a result, UNAIDS is currently working with **Liberia's** health sector to develop and implement multi-stakeholder communication frameworks to improve quantification, orders, and deliveries of medicines along the supply chain.

The project generated high-level political will and buy-in for community-led monitoring.

In several countries, the watchdog role of people living with HIV was formalized in national policy documents, frameworks and agreements.

Figure 11. Configuration of the Community Consultative Group in Benin

National Council for the Fight against HIV/AIDS, Tuberculosis, Malaria, Hepatitis, Sexually Transmitted Infections and Epidemics (CNLS-TP) (Chair)		
Joint United Nations Programme on HIV/AIDS (UNAIDS) (Vice Chair)		Benin Network of Associations of People Living with HIV (REBAP+) (Secrétariat)
Global Fund Country Coordinating Mechanism	Health Programme for the Fight against AIDS (PSLS)	Plan International (Benin)
The United Nations Children’s Fund (UNICEF)	World Health Organization	Representative of people living with HIV
Key populations representative (men who have sex with men, sex workers, people or inject drugs)	Women’s representative	Representative of young people
Health facility representative (from among the monitored sites)	Data collectors	Centre for Reflection and Action for Integrated Development and Solidarity (CeRADIS)

In other countries, the project ensured that community-led monitoring was enshrined in national strategies and plans. In **Benin**, following the implementation of the CCG’s Advocacy Plan on 30 November 2018, specific commitments were made by various partners. These commitments, broken down into activities, were transferred to the operational plan that is linked to **Benin’s** National Integrated Strategic Elimination Plan (PSNIE) for the three diseases. In **Mali**, the CCG ensured that community treatment observatory activities were included in the country’s acceleration plan for the 90-90-90 targets. This provides an entry point for sustainable national funding for community-led monitoring work.

The project also helped deepen the collaboration among networks of people living with HIV and other networks of key and vulnerable populations. The nature of the project made this cooperation a necessity, given that each indicator collected by the treatment observatory was disaggregated by men who have sex with men, sex workers, people who inject drugs, pregnant women, young men age 15-24 years and young women age 15-24 years. In **Sierra Leone**, the treatment observatory held dedicated

meetings with key populations every six months, developing new and stronger relationships with networks of female sex workers, men who have sex with men, people who inject drugs, and communities affected by tuberculosis (TB). Evidence generated from the community treatment observatory was used to stimulate discussions. In **Guinea-Conakry**, the treatment observatory cascading the training it received from ITPC to other associations of people living with HIV as well as groups of men who have sex with men and sex workers.

Another way we institutionalized community-led monitoring was by establishing common understanding of what a community treatment observatory is, with a set of minimum standards for how it should operate. To date, there have been few such efforts to systematize community-led monitoring initiatives. We developed a formal accreditation process for community treatment observatories. The process takes approximately three days per country, and is guided by an electronic tool. Our accreditation tool assesses the strength of community treatment observatories along 19 indicators and four dimensions (education, evidence, engagement, advocacy). After the

Figure 12. Results of Accreditation Process for our Community Treatment Observatories in West Africa*

IN PROGRESS	DISTRICT LEVEL	NATIONAL LEVEL
Benin Liberia Mali	The Gambia Ghana Guinea-Conakry	Côte d’Ivoire Senegal Sierra Leone Togo

*Due to the early closure of the community treatment observatory in Guinea-Bissau, an accreditation was not conducted there.

accreditation, the tool auto-generates a score (out of 100%), and a functionality tier: in progress (lowest tier), district level (mid-tier), or national level (top tier).

We accredited each of the community treatment observatories in our regional project based on their category (Fig 12). Community treatment observatories in progress included **Benin, Liberia** and **Mali**. These observatories were typically doing data collection only in the capital cities, with a limited number of data collection sites. Those operating at the district level – **The Gambia, Ghana** and **Guinea-Conakry** – had sites outside of capital cities, and had data for at least 10% of the total population of people living with HIV in the country. **Côte d’Ivoire, Senegal, Sierra Leone** and **Togo** were accredited as community treatment observatories operating at the national level. These had data collection at provincial and national-level facilities, covering at least 20% of all people living with HIV. The accreditation enabled us to be more tailored and targeted with our capacity building in each country.

The project also improved the credibility and reliability of communities as researchers, further entrenching community-led monitoring within national HIV responses. By partnering with an academic institution, Programme Agence Nationale de Recherche sur le Sida Coopération **Côte d’Ivoire** (PAC-CI), the learning from our project became robust knowledge production. The project went through formal ethics approval processes with Institutional Review Boards in **Benin, Côte d’Ivoire, Ghana, Guinea-Bissau** and **Liberia**.

Our work was accepted for presentation at international conferences, including the International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA), the annual Conference on Retroviruses and Opportunistic Infections (CROI), and the International AIDS Society (IAS) Conference on HIV Science. Our results were published as peer-reviewed papers by the Journal of Health Design and by the AIDS and Society Research Unit at the University of Cape Town’s Centre for Social Science Research. The rigorous academic review process lends credence to the competence of communities as researchers and partners in national HIV responses. This changed the way that networks of people living with HIV were perceived. Clinics were now calling on community data collectors for help with monitoring.

“ The ITPC Project enables people living with HIV—who are the primary beneficiaries of the program—to contribute to its improvement. They act as an early warning system, monitoring trends in the achievement of the 90-90-90 targets. ”

— Dr. Fatou Niassé-Traoré, CNLS
SENEGAL

Limitations

The RCTO-WA was designed and implemented as a community-led advocacy project, and not a controlled research study. While we aimed to be as rigorous as possible, there are certain limitations inherent in this approach. For example, the number of health facilities was not held constant throughout the project. We began with 103 health facilities, later adding 22 more as interest in the project grew. Similarly, the qualitative data collection

took time to hit stride. We completed 155 interviews and focus group discussions in the first six months of the project, compared to 1097 in the last six. We also acknowledge the disparate sizes and capacities of the treatment observatories in the different countries; communities monitored 2 health facilities in **Benin** and 23 in **Côte d'Ivoire**. Our ongoing community-led monitoring work takes cognizance of these lessons, further systematizing our methodological approach.

CONCLUSION

These change stories are compelling evidence for how community-led monitoring catalyses national HIV responses. Using data as an entry point, our model strengthened the link between health and community systems, making both more resilient and sustainable. We realized that giving the alert was not enough. We needed to double check that action was being taken to address the stock-outs. We had to monitor access and quality along the entire care continuum. We had to build enduring capacity and relationships.

2020 is a year of opportunities. The Fast-Track targets are due, and countries will be held accountable for their commitments to treatment access. Countries will write and

submit their funding requests for the largest-ever investment from the Global Fund to Fight AIDS, Tuberculosis and Malaria. A new cycle of national strategic plans must lay out a clear vision for how the next decade will be the one to end AIDS.

Harnessing these opportunities is critical. Using the model developed through our project in West Africa, we replicated the model and implemented community treatment observatories in Southern Africa (Malawi, Zambia and Zimbabwe). Other partners have also scaled-up their focus on community-led monitoring around the world. Now is the time to invest in the power of communities.

ANNEXES

Country Results Profiles



CÔTE D'IVOIRE

Community Treatment Observatory Results Profile

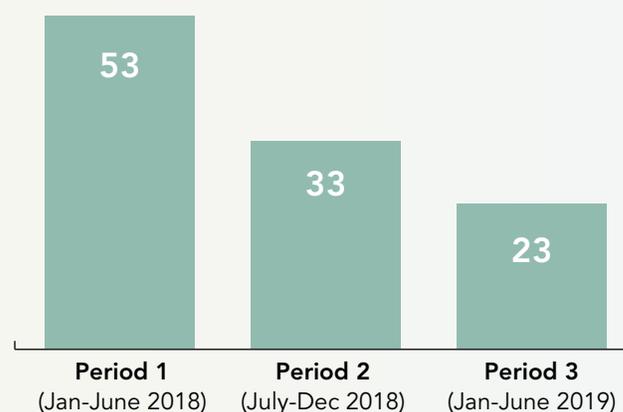
Overview

ITPC PARTNER: Le Réseau Ivoirien des organisations de Personnes vivant avec le VIH-SIDA (RIP+)			
# of health facilities CTO-monitored	# of monthly quantitative reports	# of key informant interviews	# of focus group discussions
27	389	600	34

Key Results

- At the CTO-monitored health facilities, the total number of people receiving ART increased from 111,739 in period 1 (January-June 2018), to 191,126 in period 2 (July-December 2018) to 199,687 in period 3 (January-June 2019).
- The speed with which ART stock-outs were resolved drastically improved, falling from 53 days in period 1, to 33 days in period 2, to 23 days in period 3 (Fig. 14).
- The number of key populations (men who have sex with men, sex workers, and people who inject drugs) who received a viral load test rose from 196 in period 1, to 420 in period 2, to 501 in period 3.
- In part due to advocacy led by the observatory, there was an April 2019 commitment from the government of Côte d'Ivoire to remove all user fees for people accessing HIV testing and treatment services.
- Close proximity to ITPC-West Africa office in Abidjan enhanced the quality and intensity of available technical support.
- There was high-level political buy-in for community-led monitoring, in part through strategic representation on the Community Consultative Group (CCG). This included members from the Global Fund CCM, the National AIDS Control Program, the National Commission of Human Rights, and the Central Drug Supply.

Figure 13. Average Length of ART Stock-outs at the CTO-Monitored Health Facilities in Côte d'Ivoire



Success Factors

- A large number of sites in the sample enabled the observatory to make meaningful inferences on national trends.

There was strong information sharing with other partner programs, including PEPFAR. This was done through having PEPFAR partners on the CCG (EGPAF, ACONDA VS), presenting results at the Embassy in Abidjan, and sharing findings at the COP review in Johannesburg in 2018. Ultimately, this led to the observatory securing funding to continue its work.

Next Steps

- Funding should be secured in the next Global Fund funding request to maintain or scale up the community treatment observatory in Côte d'Ivoire during the 2020-2022 funding cycle.

- Community-led advocacy is needed surrounding the Ministry's note to stop charging user fees. Not all health facilities are aware of it and enforcing it.
- Health centers need training on providing services to key populations. Only one of the 27 CTO-monitored sites is currently providing services to these groups. To increase treatment coverage, key population drop-in centers need to be able to provide ART.

Contact Details

[Alain Manouan, ITPC](#)

[Blanche Bakon, RIP+](#)

GHANA

Community Treatment Observatory Results Profile

Overview

ITPC PARTNER: National Network of Persons Living with HIV in Ghana (NAP+ Ghana)			
# of health facilities CTO-monitored	# of monthly quantitative reports	# of key informant interviews	# of focus group discussions
16	167	101	10

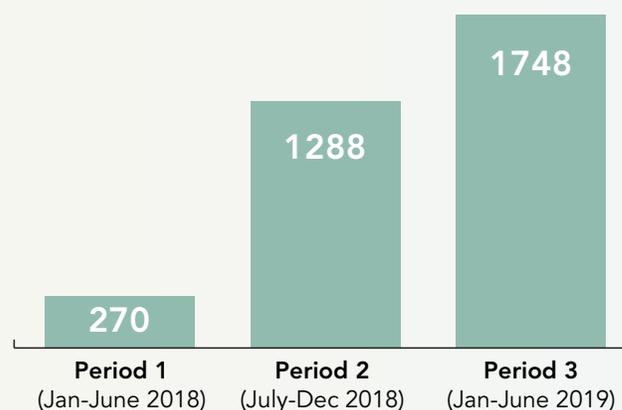
Key Results

- With collaboration between the community treatment observatory and the National AIDS Control Program, there have been no major ART shortages in Ghana since 2018
- At the CTO-monitored health facilities, the total number of people initiating ART increased more than six-fold, rising from 270 in period 1 (January-June 2018), to 1288 in period 2 (July-December 2018), to 1748 in period 3 (January-June 2019) (Fig 14).
- The proportion of people living with HIV that received their viral load test results back within two weeks of taking the test rose from 47% in period 1, to 67% in period 2, and was maintained at 66% in period 3.
- The observatory in Ghana consistently drew attention to the lack of data available for key populations. The Ghana AIDS Commission has since developed the Ghana Key Population Unique Identification System (GKPUIS) to help disaggregate key populations service data at health facilities.

community treatment observatory and health facility staff. Directors, hospital administrators, ART in-charges, data and information officers, laboratory technicians and midwives were all actively involved in the project at the monitored health facilities

- The Community Consultative Group took a leadership role in implementing the advocacy agenda. The CCG met with the head of the Tamale Teaching Hospital to discuss the viral load machine breakdown,

Figure 14. Number of People Initiating ART at the CTO-Monitored Health Facilities in Ghana



Success Factors

- There was strong collaboration among the

and met with chiefs and opinion leaders to address issues related to HIV stigma and discrimination among key populations.

Next Steps

- Funding should be secured in the next Global Fund funding request to maintain or scale up the community treatment observatory in Ghana during 2020-2022.
- Monitoring of the GKPUIS roll-out is needed, to ensure facilities collect and use disaggregated data on service access for key populations. There may be an opportunity to do this work with the \$3.1 million in Global Fund matching funds for scaling up community-led key population

programs, available for the 2020-2022 funding cycle.

- Ghana is the hub for the newly established PEPFAR West Africa Regional program, which includes Ghana, Burkina Faso, Liberia, Mali, Senegal, and Togo. PEPFAR should invest in the community treatment observatory's activities in the Western Region of Ghana, where the program is focused, to achieve the stated aim of epidemic control by September 2020.

Contact Details

[Alain Manouan, ITPC](#)

[Jonathan Tetteh-Kwao, NAP+](#)

MALI

Community Treatment Observatory Results Profile

Overview

ITPC PARTNER: Réseau Malien des Personnes vivant avec le VIH (RMAP+)			
# of health facilities CTO-monitored	# of monthly quantitative reports	# of key informant interviews	# of focus group discussions
4	63	293	16

Key Results

- At the CTO-monitored health facilities, the total number of key populations (men who have sex with men, sex workers and people who inject drugs) who received an HIV test more than doubled, rising from 1187 in period 1 (January-June 2018), to 1626 in period 2 (July-December 2018), to 2576 in period 3 (January-June 2019).
- At the CTO-monitored health facilities, the average number of days it took to resolve an ART stock-out fell from 37 days in period 1, to 27 days in period 2, and was maintained at 28 days in period 3.
- At the CTO-monitored health facilities, the total number of people on ART more than doubled, rising from 18,213 in period 1, to 36,971 in period 2, to 42,909 in period 3 (Fig 15).

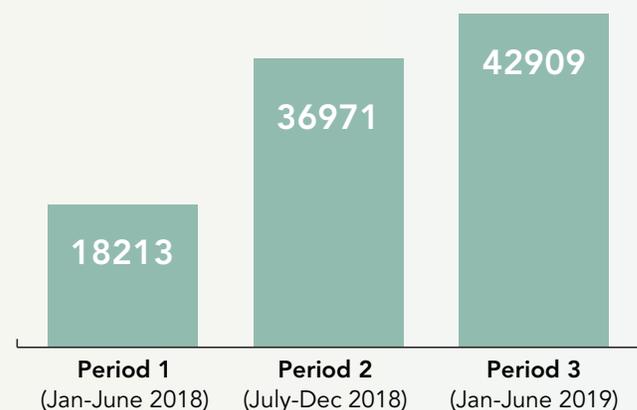
Success Factors

- A dedicated advocacy day with a clear theme (delays in receiving viral load results) resulted in a formal tri-partite contract with the national AIDS council (SE/HCNLS) and the Malian network of people living with HIV (RMAP+). RMAP+ is now an active partner in

ensuring recipients of care get their viral load results in a reasonable time.

- The Community Consultative Group used data from the treatment observatory to influence national policy documents. This contributed to the February 2019 launch of Mali's differentiated service delivery strategy, which has focused approach for HIV testing, prioritizing key populations and self-testing options. The CCG also ensured that community treatment observatory activities

Figure 15. Total Number of People on ART at the CTO-Monitored Health Facilities in Mali



were included in the country's acceleration plan for the 90-90-90 targets.

- Despite early challenges, the community treatment observatory persisted and was determined to improve. It succeeded. Compared to baseline, the treatment observatory in Mali achieved some of the greatest gains in the region.

Next Steps

- Funding should be secured in the next Global Fund funding request to maintain or scale up the community treatment observatory in Mali.

- Continued advocacy is needed to ensure that the growing number people initiated onto ART are monitored properly. Access to viral load testing services remains a significant challenge in Mali.
- Disaggregated data is needed for key populations. There is limited availability of key population data at 3 of the 4 Mali CTO-monitored sites.

Contact Details

[Alain Manouan, ITPC](#)

[Dramane Koné, RMAP+](#)

SIERRA LEONE

Community Treatment Observatory Results Profile

Overview

ITPC Partner: Réseau Malien des Personnes vivant avec le VIH (RMAP+)			
# of health facilities CTO-monitored	# of monthly quantitative reports	# of key informant interviews	# of focus group discussions
21	305	13	15

Key Results

- With sustained advocacy from the treatment observatory, Sierra Leone launched a policy on differentiated service delivery in March 2019. This policy includes community-based testing options for key populations, coupled with peer navigation to increase linkage to prevention and treatment services.
- At the CTO-monitored health facilities, the total number of key populations (men who have sex with men, sex workers and people who inject drugs) who received an HIV test more than doubled, rising from 1067 in period 1 (January-June 2018), to 2065 in period 2 (July-December 2018), to 2445 in period 3 (January-June 2019) (Fig 16).
- At the CTO-monitored health facilities, the total number of key populations (as defined above) on ART nearly tripled, increasing from 266 in period 1, to 486 in period 2, to 736 in period 3.

Success Factors

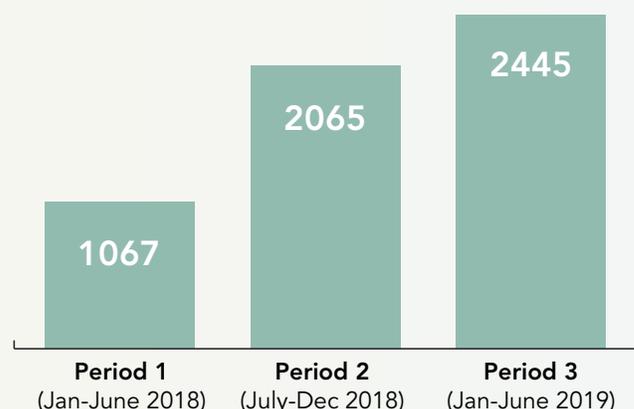
- Publication of Sierra Leone’s community treatment observatory results in The Journal of Health Design helped demonstrate to government decision-makers that the model was robust, and that community-led

monitoring data reliable and credible.

- Joint action by National AIDS Secretariat and National AIDS Control Programme was taken to respond to community treatment observatory stock-out alerts and immediately take HIV medicines and commodities to the facilities.
- Solidarity between general and key populations on a shared agenda strengthened overall community systems.

NETHIPS used data collected through the

Figure 16. Number of Key Populations Who Received an HIV Test at the CTO-Monitored Health Facilities in Sierra Leone



treatment observatory to mobilize additional funds from Christian Aid and from Solthis. This enabled NETHIPS to expand livelihood activities to support people's out-of-pocket expenditure on HIV services, and to build skills of network members on advocacy and proposal development, enhancing sustainability.

Next Steps

- Funding should be secured in the next Global Fund funding request to maintain or scale up the community treatment observatory in Sierra Leone. There may be

an opportunity to do this work with the \$1.5 million in Global Fund matching funds for programs to remove human rights-related barriers to health services, available for the 2020-2022 funding cycle.

- NETHIPS should be supported to monitor the implementation of Sierra Leone's new policy on differentiated service delivery, ensuring facilities adhere to the guidance.

Contact Details

[Alain Manouan, ITPC](#)

[Martin Ellie, NETHIPS](#)

TOGO

Community Treatment Observatory Results Profile

Overview

ITPC Partner: Réseau des Associations de Personnes Vivant Avec le VIH au Togo (RAS+)			
# of health facilities CTO-monitored	# of monthly quantitative reports	# of key informant interviews	# of focus group discussions
11	174	110	16

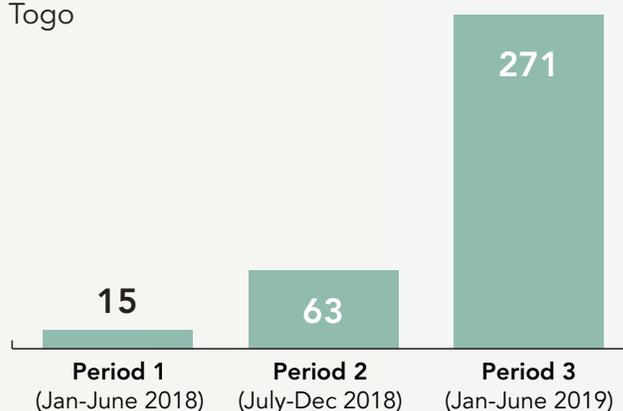
Key Results

- At the CTO-monitored health facilities, the number of key populations (men who have sex with men and sex workers) who were initiated onto ART rose 18-fold, increasing from 15 in period 1 (January-June 2018), to 63 in period 2 (July-December 2018), to 271 in period 3 (January-June 2019) (Fig 17).
- At the CTO-monitored health facilities, the number of eligible people provided with post-exposure prophylaxis (PEP) doubled, rising from 21 in period 1, to 31 in period 2, to 42 in period 3.
- At the CTO-monitored health facilities, the number of pregnant women who received an HIV test increased from 3713 in period 1, to 6553 in period 2, to 8508 in period 3.
- At the CTO-monitored health facilities, the number of young women age 15-24 years on ART increased from 769 in period 1, to 1944 in period 2, to 2032 in period 3.

meetings of the Quantifying Committee of Inputs, and meetings with civil society, CNLS/PNLS and USAID. This increased the credibility of RAS+ and attracted additional resources through PEPFAR/HP+ to continue the CTO work in COP19.

- The data collected by the community treatment observatory was seen as reliable by health facility staff. At the Sylvanus Olympio University Teaching Hospital in Lomé, Togo, the service supervisor in the prevention of mother-to-child unit used data

Figure 17. Number of Key Populations Initiating ART at the CTO-Monitored Health Facilities in Togo



Success Factors

- The community treatment observatory used their data to make evidence-informed interventions during CCM meetings,

collected by the treatment observatory to cross-checks information in its central reporting system.

- Multi-pronged advocacy with different stakeholders was used to find a solution to viral load stockouts. The community treatment observatory successfully advocated with CNLS/PNLS to make a budget line for preventive maintenance of equipment, and with PEPFAR to support the continuous availability of reagents.

Next Steps

- Funding should be secured in the next Global Fund funding request to maintain or scale up the community treatment observatory in Togo.

- Following the pre-exposure prophylaxis (PrEP) trial among men who have sex with men in Togo – which the treatment observatory monitored – advocacy is needed to ensure that national policy is updated and demand is created to enable full PrEP rollout to key populations.

Contact Details

[Alain Manouan, ITPC](#)

[Amen Hlomewoo, RAS+](#)

FURTHER READING

ITPC Resources

[Community-led Monitoring Brief](#)

[What is a Community Treatment Observatory? Short video](#)

The ITPC Community Treatment Observatory Model, Explained
[Full](#) / [Summary](#)

[Data for a Difference: Key Findings, Analysis and Advocacy Opportunities from the Regional Community Treatment Observatory in West Africa](#)

[Regional Fact Sheet #1: Understanding Gaps in the HIV Care Continuum in 11 West African Countries](#)

[Regional Fact Sheet #2: Improving Access to Quality HIV Treatment in 11 West African Countries](#)

Conference Papers

[Abstract-driven session at the IAS 2019 Conference in July 2019, Mexico City, Mexico](#)

[Seminar at the Center for Social Science Research, September 2019, University of Cape Town](#)

[Abstract-driven session at the ICASA 2019 Conference in December 2019, Kigali, Rwanda](#)

[Abstract-driven session at the CROI 2020 Conference in March 2020, Boston, Massachusetts](#)

[Abstract-driven session at the AIDS 2020 Conference in July 2020, San Francisco/Oakland, USA](#)

In the Press

[Article published in the Global Fund Observer, June 2019](#)

[Research covered by nam aidsmap, August 2019](#)

Peer-reviewed Publications

[Ellie, M. P., Kibe, P. W., Flomo, B. M., & Ngwatu, B. K. \(2019\). Breaking Barriers: Using evidence from a Community Treatment Observatory to enhance uptake of HIV services in Sierra Leone. *The Journal of Health Design*, 4\(1\)](#)

[Oberth, G., Baptiste, S., Jallow, W., Manouan, A., Garcia, P., Traore, A.M., Murara, J. & Boka, R. \(2019\). Understanding gaps in the HIV treatment cascade in eleven West African countries: Findings from a regional community treatment observatory. *Centre for Social Science Research \(CSSR\) Working Paper No. 441*. ISBN: 978-1-77011-428-9.](#)



@ITPCglobal



facebook.com/ITPCglobal



Watch
What
Matters

REGIONAL
COMMUNITY
TREATMENT
OBSERVATORY
West Africa



ITPC
INTERNATIONAL TREATMENT
PREPAREDNESS COALITION