COMMUNITY DATA IN ACTION

Community-Led Monitoring to Improve Diagnostic & Laboratory services

Results from a pilot project in Burkina Faso, Democratic Republic of Congo and Sierra Leone in 2025

ITPC

ASLM
AFRICAN SOCIETY FOR LABORATORY MEDICINE

Lab CoP
ASLM

NETHIPS
Network of HIV Positives in Sierra Leone

UCOP+

ABOUT

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:

- Intellectual property and access to medicines (#MakeMedicinesAffordable)
- Community-led monitoring and accountability (#WatchWhatMatters)
- Activism and capacity building (#BuildResilientCommunities)

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

Watch What Matters is a community monitoring and research initiative that gathers data on access to and quality of HIV treatment globally. It fulfills one of ITPC's core strategic objectives: to ensure that those in power remain accountable to the communities they serve. Watch What Matters aims to streamline and standardize treatment access data collected by communities. It helps ensure that data is no longer collected in a fragmented way, and reflects the issues and questions that are most important to people living with and affected by HIV. It relies on a unique model that empowers communities to systematically and routinely collect and analyze qualitative and quantitative data on access barriers, and use this data to guide advocacy efforts and promote accountability. To learn more about Watch What Matters and our work, visit **itpcglobal.org/our-work/watch-what-matters**

By self-organizing and demanding their right to health, communities drive progress made in access to HIV treatment and improvements in the quality of HIV services. **Build Resilient Communities** reflects ITPC's commitment to creating meaningful partnerships within the movement and forming broader coalitions to fight for social justice. To learn more about Build Resilient Communities and our work, visit **brc.itpcglobal.org**

The **Network of HIV Positives in Sierra Leone (NETHIPS)** is an umbrella organization established for people living with HIV in Sierra Leone in 2006. Its mission is to improve access to and uptake of HIV services, ensure meaningful community engagement, and advocate for HIV-related policies, laws, and practices that uphold the human rights and welfare of communities.

The **Réseau Accès aux Médicaments Essentiels (RAME)** was established in Burkina Faso in 2003. Its mission is to influence public policies to ensure equitable access to health services through community-led monitoring of service delivery dysfunctions and advocacy.

The **Union Congolaise des Organisations des PVVIH (UCOP+)** is a network of organizations led by people living with HIV and created in the Democratic Republic of Congo (DRC) in 2007. Its mission is to improve the quality of life of people living with HIV by defending their rights through community leadership and empowerment.

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To download this report from the ITPC website, click here.

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TABLE OF CONTENTS

ABBREVIATIONS

AAAQ	Availability, Accessibility, Acceptability and Quality
AHD	Advanced HIV disease
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
ASLM	African Society for Laboratory Medicine
BRC	Build Resilient Communities (ITPC initiative)
CCM	Country Coordinating Mechanism (Global Fund)
CD4	Cluster of Differentiation 4
CHC	Community health center
CHR	Regional hospital (*Centre Hospitalier Régional*)
CHU	University hospital (*Centre Hospitalier Universitaire*)
CHUR	Regional University Hospital (*Centre Hospitalier Universitaire Régional*)
CLM	Community-led monitoring
CMA	Medical Centre with Surgical Unit (*Centre Médical avec Antenne chirurgicale*)
COBAS	Automated laboratory system by Roche Diagnostics
DBS	Dried blood spot
DRC	Democratic Republic of Congo
EID	Early infant diagnosis
HCW	Healthcare worker
HIV	Human immunodeficiency virus
ITPC	International Treatment Preparedness Coalition
LabCoP	Laboratory System Strengthening Community of Practice
MoH	Ministry of Health
NAAT	Nucleic acid amplification testing
NETHIPS	Network of HIV Positives in Sierra Leone
NGO	Non-governmental organization
NVP	Nevirapine
PCMH	Princess Christian Maternity Hospital (Sierra Leone)
PCR	Polymerase chain reaction
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
POC	Point of care
PrEP	Pre-exposure prophylaxis
RAME	*Réseau Accès aux Médicaments Essentiels*, Burkina Faso (Access to Essential Medicines Network)
RoC	Recipient of care
SD	Standard Diagnostics
SS	Sourou Sanou University Hospital (Burkina Faso)
TB	Tuberculosis
UCOP+	Congolese Union of Organizations of PLHIV (*Union Congolaise des Organisations des PVVIH* - UCOP+)
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VL	Viral load
WHO	World Health Organization

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EXECUTIVE SUMMARY

Community-led monitoring (CLM) has highlighted gaps in access to HIV diagnostic and laboratory servicesrecommended by the World Health Organization (WHO) and nationally, providing a deeper look at the impact of these gaps on health outcomes. The data CLM generates provides evidence and a pathway for advocacy to improve access to and quality of HIV services.

Ensuring equitable access to essential HIV diagnostic, laboratory, and screening services upholds the human right to health and improves treatment outcomes, quality of life, and survival among people vulnerable to or living with HIV. These services include HIV testing, early infant diagnostics, CD4 count, viral load monitoring, and routine tuberculosis (TB) symptom screening. Data from these tests enable program planning, surveillance, and assessment of national, regional, and global HIV responses and progress towards the Joint United Nations Agency on HIV/AIDS (UNAIDS) 2030 95-95-95 targets.

Stockouts, staff shortages, power outages, persistent weaknesses in supply chains, equipment maintenance systems, and poor results management have created gaps in, and compromised access to, the quality of HIV diagnostic and laboratory services across many low- and middle-income countries, endangering HIV outcomes and achievement of global goals and targets to end the HIV pandemic. In January 2025, the United States President's Emergency Plan for AIDS Relief (PEPFAR) "stop-work" order, funding cuts, and the rapid disbandment of the United States Agency for International Development (USAID) caused further disruptions to HIV services in many countries.

To provide insight about the impact of US funding cuts and inform advocacy to improve access to and quality of HIV diagnostic and laboratory services, the International Treatment Preparedness Coalition (ITPC) implemented a pilot CLM project on HIV diagnostic and laboratory services with its community partners in Burkina Faso, the Democratic Republic of Congo (DRC), and Sierra Leone and with support from the African Society for Laboratory Medicine (ASLM) through its Laboratory System Strengthening Community of Practice (LabCoP).[1] The pilot was designed to monitor whether health facilities followed WHO and/or national guidelines and to assess long-standing systemic challenges, as well as impacts resulting from the 2025 funding reductions.

The 2025 CLM for Laboratories pilot project objectives were:

1. Monitoring availability and accessibility of HIV testing, with a focus on self-testing; early infant diagnosis (EID), CD4 cell count testing, HIV viral load monitoring, and TB screening
2. Identifying underlying causes of dysfunctions in these testing and screening services
3. Documenting impacts of the 2025 US funding cuts on the provision of these services
4. Using CLM data to advocate for improved diagnostic and laboratory services

[1] LabCop facilitates peer learning and practical problem-solving among multidisciplinary country teams to address gaps in HIV laboratory systems.

The 2025 CLM for Laboratories pilot project collected data, prospectively and retrospectively, from 11 primary, 19 secondary, and four tertiary-level health facilities between June and August 2025, covering the period of July 2024 to June 2025. This included clinical data from 57,803 people living with HIV, qualitative data from 481 recipients of care (RoCs), and 59 interviews with healthcare workers.

The 2025 CLM for Laboratories pilot project generated key findings and recommendations, as follows:

Finding 1:
The 2025 US funding cuts exposed donor dependence for core functions and exacerbated existing fragile procurement systems.

Recommendation:
Institutionalize national procurement budgets and mechanisms to reduce donor dependency.

Finding 2:
Stockouts and equipment malfunctions are the main disruptors of diagnostic and laboratory service continuity.

Recommendation:
Strengthen national supply chains and maintenance systems to end recurrent stockouts.

Finding 3:
Results of viral load monitoring are delayed and clinical management is weak.

Recommendation:
Strengthen viral load result management and clinical follow-up systems.

Finding 4:
CD4 cell count testing is underprioritized, especially in Burkina Faso and the DRC, undermining continuity of advanced HIV care.

Recommendation:
Reprioritize CD4 testing to strengthen advanced HIV disease management.

Finding 5:
Community-led monitoring revealed gaps across the diagnostic cascade that are not captured by routine national monitoring systems.

Recommendation:
Institutionalize CLM in national monitoring systems and ensure strong community engagement in the design, implementation, and monitoring of laboratory services.

Project data was also used for national advocacy plans, which were implemented in August and September 2025. Through national dialogues, multistakeholder workshops, and strategic engagement with ministries of health and Global Fund principal recipients, civil society networks secured concrete commitments to strengthen procurement planning, reinforce maintenance systems, and institutionalize regular communication between government and community actors.

BACKGROUND

Why are HIV diagnostic and laboratory services important?
HIV diagnostics anchor the cascade of care, from diagnosing HIV in infants, children, adolescents, and adults – which enables initiation of life-saving antiretroviral therapy (ART) and offers the additional benefit of preventing vertical and sexual transmission – to identifying ART failure and severe immune deficiency and preventing illness from tuberculosis (TB).

Effects of the 2025 US funding cuts
The 2025 Trump administration's major cuts to US global HIV assistance, including PEPFAR- and USAID-funded programs, led to the termination or suspension of support for several implementing partners and facilities across African countries, directly affecting laboratory systems, supply chains, and community-based activities previously sustained through US funding.

As a response, ITPC adapted its CLM model to document the early effects of the funding cuts on laboratory services, alongside routine monitoring of essential HIV testing and screening indicators. US-funded and non-US-funded sites were included to assess any impact of the US funding cuts, and the data collection period was adjusted to include January-June 2025, in addition to July-December 2024.

The framework for this CLM project is based on WHO and national guidelines. The rationale for prioritizing certain tests for this CLM project is as follows:

- **TB screening**, using WHO's four-symptom TB screening (W4SS: cough, fever, weight loss, and night sweats) to identify people for further TB testing and, if indicated, treatment. TB is the leading cause of death among people living with HIV, who are up to 22 times more likely to fall ill from TB than HIV-negative people.

- **Early infant diagnostics** (EID), using nucleic acid amplification testing (NAAT), to enable ART initiation among infants living with HIV. Without ART, a third of infants born with HIV will die before their first birthday and one-half will die by their second birthday.

- **HIV testing** to identify people living with HIV and link them with life-saving HIV treatment and services.

- **CD4 cell count**, recommended by WHO as the preferred method for identifying people with advanced HIV disease[2] (AHD: people with a CD4 cell count of <200 cells/mm^3, and all children living with HIV under the age of five years, unless they have received ART for more than a year and are clinically stable).

People living with AHD have weakened immune systems, leaving them vulnerable to severe illness and death, and they require a special package of care and treatment. In low- and middle-income countries, over a third of all people living with HIV who initiate or re-enter care have AHD;[3] nearly half have no symptoms, underscoring the importance of CD4 count.[4] Without treatment, survival among people with AHD is 48% after two years, dropping to 26% at four years and 18% at six years.

[2] https://iris.who.int/server/api/core/bitstreams/68dfe26f-ad54-4f60-b92f-b943b1a0d82c/content
[3] https://onlinelibrary.wiley.com/doi/full/10.1002/jia2.26415
[4] https://www.nejm.org/doi/10.1056/NEJMoa1615822

Access to CD4 testing is increasingly relevant in the context of funding cuts, which may disrupt access to HIV testing and ART – both of which could increase the incidence of AHD. If HIV treatment disruptions and interruptions continue, CD4 cell count may be necessary for prioritizing eligibility for ART initiation or reinitiation.

- **HIV viral load monitoring** is important to assess – and address – response to ART. The goal of HIV treatment is an undetectable viral load, which means that ART is working to keep the immune system strong, improving health, quality of life, and survival among people living with HIV – and it can prevent vertical and sexual HIV transmission.

Viral load testing identifies HIV treatment failure. An unsuppressed viral load (>1,000 copies/mL) puts people living with HIV at increased risk of illness and increases likelihood of transmission. People living with HIV who are experiencing treatment failure receive enhanced adherence counseling and continued monitoring, and they may switch their ART.

Purpose of the 2025 CLM for Laboratories pilot project

The CLM pilot project to improve diagnostic and laboratory services was implemented in Sierra Leone, Burkina Faso, and the Democratic Republic of Congo (DRC) in 2025 with the purpose of:

1. Monitoring availability and accessibility of HIV testing, with a focus on self-testing; early infant diagnosis (EID), CD4 cell count testing, HIV viral load monitoring, and TB screening
2. Identifying underlying causes of dysfunctions in these testing and screening services
3. Documenting impacts of the 2025 US funding cuts on the provision of these services
4. Using CLM data to advocate for improved diagnostic and laboratory services

This pilot was designed to monitor whether health facilities followed WHO algorithms in the context of both long-standing systemic challenges and the 2025 funding reductions.

Rationale for using CLM

ITPC and its partners have extensive experience using CLM to analyze Access, Availability, Accessibility, Acceptability, and Quality[5] (AAAQ) to enable communities to identify gaps and advocate for improvements in access to and quality of services. ITPC's CLM model has been applied across Africa, Asia, and Latin America, leading to improvements in healthcare delivery for people living with HIV, as well as key and vulnerable populations.

Previous ITPC initiatives include awareness and demand-generation campaigns on viral load (VL) monitoring in six African countries (the DRC, Malawi, Kenya, Sierra Leone, South Sudan, and Zimbabwe), and a 2022 CLM pilot on VL monitoring and CD4 testing in Kenya and Sierra Leone[6] implemented in partnership with the African Society for Laboratory Medicine (ASLM).

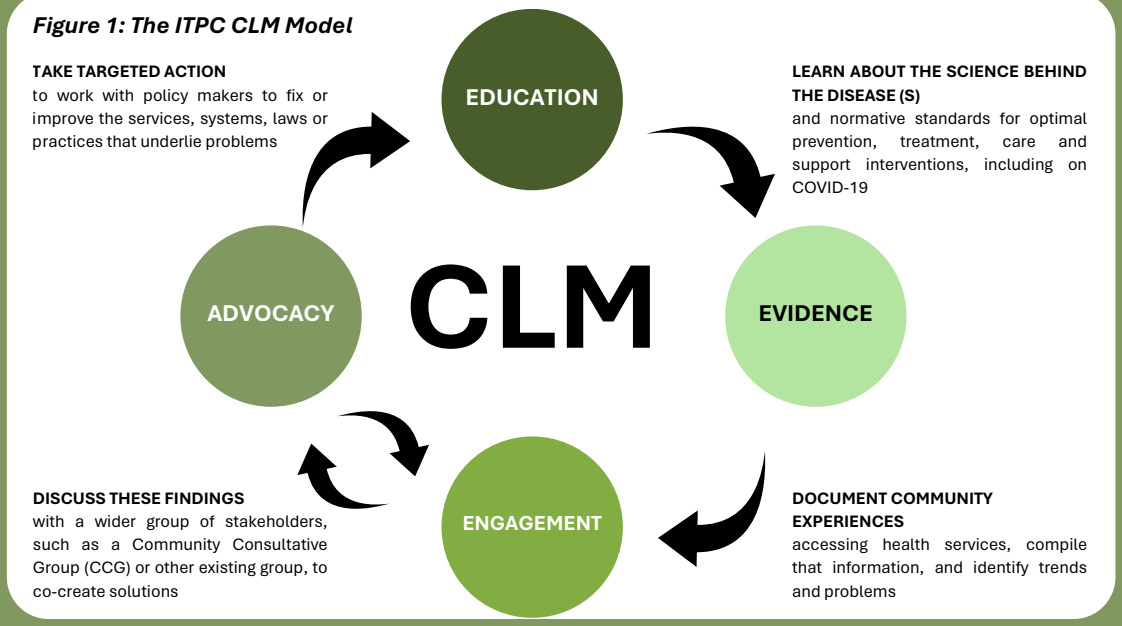
These pilot projects showed that supportive national policies alone were insufficient as countries continued to face systemic and supply-side barriers that limited access to high-quality diagnostic services. This 2025 CLM pilot project built on previous experiences and was designed to leverage the power of CLM to identify barriers and develop practical, people-centered solutions to close gaps in essential HIV-related diagnostic and laboratory services.

[5] UNICEF. AAAQ Framework. https://gbvguidelines.org/wp/wp-content/uploads/2019/11/AAAQ-framework-Nov-2019-WEB.pdf

[6] https://itpcglobal.org/wp-content/uploads/2023/08/CLM-for-Labs.pdf

ITPC's CLM model starts with education. Communities need current and updated information about HIV science and WHO and national normative guidelines, which define the standard of care they are entitled to. This information provides a baseline for identifying gaps in access to and quality of HIV services. The model uses rigorous methods to document and analyze lived experience and engagement with key stakeholders to identify solutions for service shortfalls; it also includes advocacy for improving access to and quality of services.

Figure 1: The ITPC CLM Model



EDUCATE: CLM starts with engagement of people who are recipients of services and others who are living with or vulnerable to prevalent health issues. Through meetings and trainings, people in communities learn about the commodities, services, and standards they should expect, and then identify priority concerns they might have with services, programs, and policies. This community engagement forms the basis for defining CLM indicators, data collection tools and methods, and strategies for use of CLM data for evidence-based engagement and advocacy with program managers and policy makers.

EVIDENCE: CLM programs employ recipients of care and other community members to collect data – which is localized, actionable evidence towards the goal of helping service providers and people intended to benefit to identify problems and potential improvements. Both quantitative and qualitative data are collected on a routine recurring basis and then compiled and analyzed. The data collection, analysis, and reporting are led by community organizations. To reduce bias, the community monitors are necessarily independent from the programs and providers being monitored.

ENGAGE: Community leaders and recipients of care meet regularly with service providers, program managers, and policy makers to review evidence, jointly develop solutions to identified problems, and co-create solutions.

ADVOCATE: When potential improvements to programs and policies are slow to come, advocacy promotes change. Advocacy is especially powerful when it is backed by CLM-generated evidence, along with strong communications and sustained relationships with decision-makers.

METHODS

Figure 2: Countries where the pilot project was implemented

A desk review of WHO and national HIV and TB guidelines in Burkina Faso, the DRC, and Sierra Leone was performed in April-May 2025. In consultation with project partners, the review informed the prioritization of diagnostics for this pilot project.

ITPC and partners from the three implementing countries gathered for a virtual two-day inception workshop on 19 and 20 May 2025. Partners were RAME (Burkina Faso), UCOP+ (DRC), and NETHIPS (Sierra Leone). The workshop covered WHO and national guidelines for, and the importance of, prioritized tests and testing technologies and how facilities administer the tests. It included discussions with country partners about proposed quantitative and qualitative indicators, the format of the CLM indicator framework, logistics, and the timeline for implementing the pilot project.

Following this consultation, data collection tools, including quantitative and qualitative indicators, were reviewed by implementing partners and developed in paper-based and electronic versions. The qualitative and quantitative indicators that informed the data collection tools are listed in Annex 1. Implementing partners reviewed the tools, and the final paper-based tool was transferred onto an online data collection system called Alchemer. On 5 June, 60 people were trained on data collection methods and provided feedback on the data collection tools. The finalized data collection tools included:

- A health facility survey to gather clinical data and qualitative feedback from healthcare workers
- A recipient of care (RoC) survey to gather feedback on TB screening, CD4 cell count and VL monitoring
- A version of the RoC survey adapted for use during focus group discussions

In addition, a health quality framework was utilized to review how to improve laboratory efficiency. Hence, issues of availability (stockouts, regularity), accessibility (costing, transport), appropriateness (understanding of tests and results by RoCs), and quality (satisfaction with additional care) were explored.

US-funded and non-US-funded sites were included to assess any impact of the US funding cuts. The aim to document the impact of the US funding cuts also informed the data collection period to include January-June 2025, in addition to July-December 2024. Data sites were also classified as primary (peripheral health units), secondary (district hospitals), and tertiary (regional/teaching hospitals for specialized care). Find the list of data sites in Annex 2.

Quantitative data on HIV testing, early infant diagnosis, CD4 testing, and viral load monitoring were then collected from the health registers of monitored health facilities for two periods: July to September and October to December 2024; and January to March and April to June 2025. Qualitative data on TB screening, CD4 testing, and VL monitoring were collected from RoCs attending health facilities and from healthcare workers. Furthermore, healthcare workers provided qualitative data on HIV testing and early infant diagnosis.

Data collection lasted approximately 1.5 months from mid-June to early August 2025, and implementing partners regularly verified the quality of the data collected through support meetings and quality checks by ITPC. Advocacy plans were developed based on the insights from the preliminary data analysis and field observations. The template used to develop the advocacy plans is provided in Annex 3. The advocacy action plans were implemented between August and September 2025.

The main limitations of this pilot project were:

- The scope of the pilot project included a sampling of health facilities in the three countries, limiting representativeness on a broader scale.
- The three-month time frame for data collection and advocacy limited the ability to evaluate the long-term impact of issues highlighted through the CLM and did not allow for monitoring of improvements in diagnostic and laboratory services over time.
- All countries reported challenges in obtaining data from RoC records due to weak documentation systems at health facilities. This occurred in all countries on data related to follow-up of unsuppressed viral load, and for people with a CD4 cell count of <200 cells/mm^3. In Burkina Faso, this applied to all CD4 cell count testing indicators.
- Data collection on CD4 cell testing attempted to assess whether CD4 cell testing was performed at HIV diagnosis, when re-entering HIV care, and with adherence counseling for people with an unsuppressed viral load. However, facility health records did not systematically classify the CD4 testing in this manner, and the data obtained were not complete enough to analyze at that level of granularity.
- Advocacy activities and engagement with health authorities were based on preliminary data analysis and field observations. In-depth data analysis was conducted after the implementation period to produce this report. It provided more in-depth data trends (such as reasons for limited access to follow-up care and treatment and reasons for low prioritization of CD4 cell testing), which could not be fully explored due to limited access to the relevant stakeholders to discuss these after the close-out of the implementation phase.

FINDINGS

Application of the CLM model in monitoring of HIV-related diagnostic and laboratory services

Country partners implemented the CLM model across 34 facilities (12 in Burkina Faso, 10 in the DRC, and 12 in Sierra Leone) between 1 July 2024 and 30 June 2025. This was made up of 18 US-funded sites and 16 non-US-funded sites covering 29 districts (Table 1). The analysis covered the following essential diagnostics: HIV testing, TB screening, early infant diagnosis (EID), CD4 cell count, and viral load monitoring. It assessed the functionality, accessibility, and quality of services supporting HIV care across the three countries.

As detailed below, 60 data collectors conducted 59 interviews with healthcare workers (HCWs), collected clinical data on 57,803 people living with HIV, and interviewed 481 RoCs. The HCWs interviewed included the health facility staff performing HIV testing and HIV EID, as well as the HIV care providers for monitoring of VL and CD4 among people living with HIV.

Table 1: CLM for laboratory indicators scope and reach

	Burkina Faso	DRC	Sierra Leone
Health facilities (total)	12	10	12
- **Health facilities (US-funded)**	7	5	6
- **Health facilities (non-US-funded)**	5	5	6
Districts	12	10	7
Data collectors	26	10	24
People living with HIV (total – health records)	24,450	16,215	17,138
- **Infants born to women living with HIV**	578	121	341
- **People living with HIV – CD4 cell count**	443	918	3,521
- **People living with HIV – VL monitoring**	23,429	15,176	13,276
People living with HIV (interviews)	152	111	218
Healthcare workers interviewed			
- **HIV testing**	31	22	32
- **EID**	33	14	23
- **CD4**	18	9	29
- **VL monitoring**	33	21	31

The results, firstly, reflect on the impact of the 2025 US funding cuts on laboratory systems and community-based support mechanisms. The subsequent results assess HIV testing, including self-testing availability, early infant diagnosis, CD4 testing, and viral load monitoring. The analysis assesses whether national guidelines are aligned with WHO recommendations, availability and accessibility to the service, linkage to care (CD4 testing and VL monitoring), and dysfunctions affecting the service, including stockouts of commodities and equipment malfunctions. The section ends with an assessment of tuberculosis screening practices as a component of HIV care by recipients of care.

IMPACT OF US FUNDING CUTS

Across the 34 sites monitored in the three countries, the 18 US-funded facilities described a mixed but tangible impact of the January 2025 funding freeze and subsequent cuts. Overall, the most consistent issues related to disruptions in community-led initiatives (psychosocial support and outreach activities) and lower healthcare worker morale associated with resource constraints following the freeze.

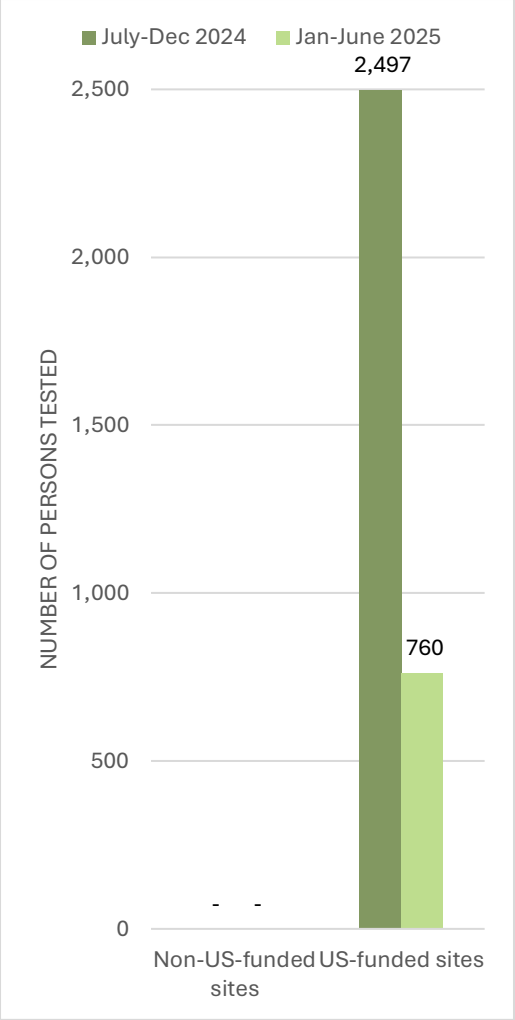
Across non-US-funded sites, indirect effects were also reported. Although these facilities did not lose direct financial support, they noted a reduction in community programs for follow-up, outreach, and client support. Supply chain issues observed at national or district levels created delays or shortages that affected service continuity among both US-funded and non-US-funded sites.

In Burkina Faso, impacts were reported as follows: (i) dissatisfaction with receiving reagents that were incompatible with testing machines; (ii) decline in staff morale; (iii) more frequent reagent stockouts; and (iv) a noticeable reduction in non-governmental organization (NGO) involvement in psychosocial support. Healthcare workers noted that US support for clinical supplies is largely channeled at national level rather than directly to health facilities. This may temporarily prevent health facilities from experiencing immediate local effects as central authorities strive to maintain a continuous supply.

Notably, within the sample of 12 facilities monitored, only US-funded facilities (two secondary district hospitals and two tertiary regional hospitals) performed CD4 cell count testing. After the funding cuts, CD4 testing volumes declined by 70% (from 2,497 to 760) from July-December 2024 to January-June 2025. According to interviews with community and healthcare workers, CD4 testing is no longer routinely performed, although WHO and national guidelines recommend it; monitoring of RoCs is done mainly through viral load monitoring.

In the DRC, health facilities reported that the US funding cuts prolonged stockouts of commodities. Several sites stopped or delayed laboratory activities for HIV testing, CD4, and viral load (including sample collection and follow-up for viral load) and reduced financial incentives for healthcare workers.

Figure 3: CD4 testing volumes by US funding status in Burkina Faso, July 2024-June 2025



In the DRC, US-funded sites perform nearly all CD4 testing, EID, and viral load monitoring. Of the eight facilities performing EID testing, six are US-funded (five primary healthcare sites and one secondary district hospital). Although no decreases in the volume of EID or CD4 testing were reported during the monitoring period, their lack of availability outside of US-funded sites creates vulnerability if financial constraints prevent sites from offering them.

Figure 5: EID testing volumes in DRC, July 2024-June 2025

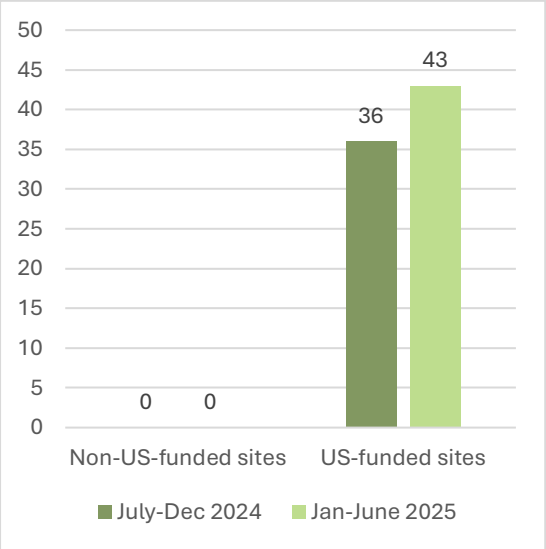


Figure 4: CD4 testing volumes in DRC, July 2024-June 2025

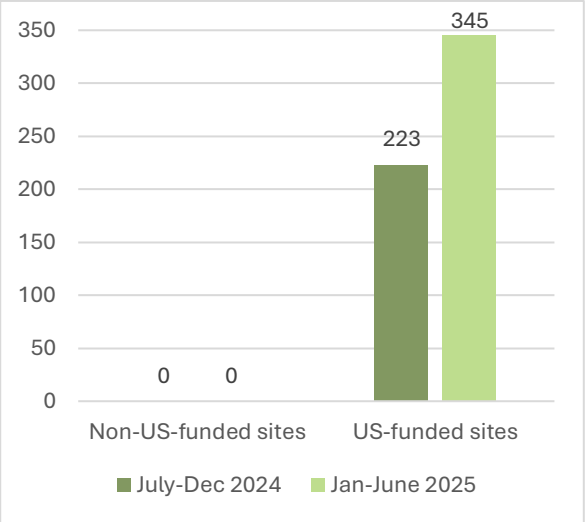
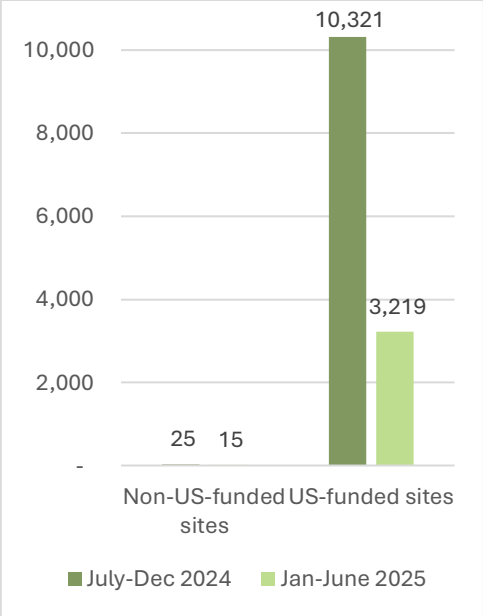


Figure 6: Viral load testing volumes in DRC, July 2024-June 2025

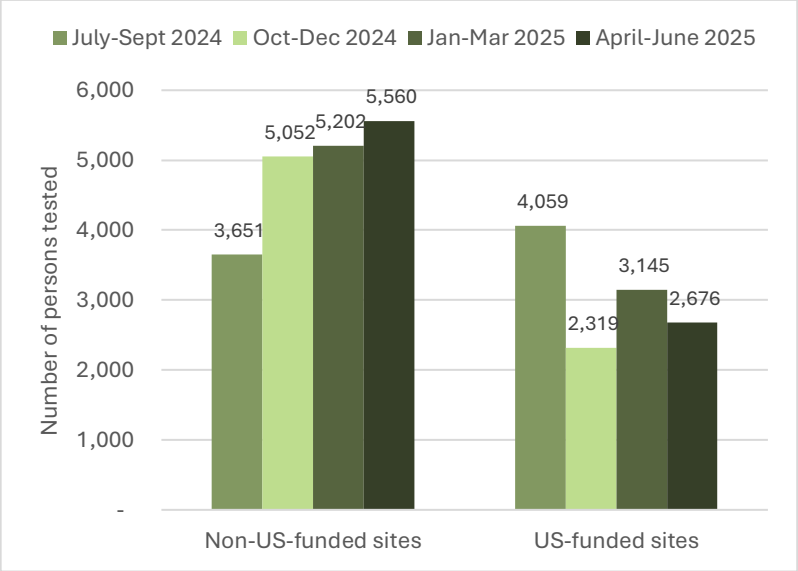


Six of the 10 facilities monitored in the DRC perform viral load monitoring; five of them are US-funded (four primary healthcare sites and one secondary district hospital). After the funding cuts, VL testing volumes declined by 69%, from 10,321 in July-December 2024 to 3,219 in January-June 2025.

In Sierra Leone, the earliest and most visible effect of the US funding cuts was the halting of stipends for community volunteers/mentor mothers, which undermined outreach activities (including lost to follow-up tracing) and psychosocial support. Healthcare workers from US-supported sites reported declines in staff morale and stockouts of HIV tests and viral load monitoring commodities. The impact on viral load services was mitigated due to commodities supplied through the Global Fund, which enabled centralized testing hubs to continue to process samples. In addition, stockouts of pediatric antiretrovirals (ARVs) were also cited. Healthcare workers also described temporary disruption to EID and CD4 services during the "stop-work" order period, though most facilities kept operating with reduced staff.

HIV testing volumes remained relatively stable in Sierra Leone through 2024. In 2025, there was a 15% decline (from 3,145 to 2,676) in the second quarter of 2025 at US-funded sites compared with a 7% increase (from 5,202 to 5,560) in non-US-funded sites (see Figure 7). This aligns with reports from healthcare workers who linked disruptions in routine laboratory operations, including stockouts, to the funding cuts.

Figure 7: HIV testing volumes by US funding status in Sierra Leone, July 2024- June 2025



There was a decline in Sierra Leone in the volume of CD4 testing and VL monitoring in early 2025, with sharper drops in US-funded sites. CD4 testing volumes decreased markedly in US-funded sites, falling from 324 in October-December 2024 to 141 in April-June 2025 compared with a decrease from 190 to 155 in non-US-funded sites over the same period (see Figure 8). The rate of viral load monitoring in US-funded sites fell from 4,421 in October-December 2024 to 1,849 in January-March 2025 before decreasing further to 627 by April-June 2025. In comparison, the number of viral load tests at non-US-funded sites fell from 1,355 to 680 over the same period (see Figure 9).

Figure 8: CD4 testing volumes by US funding status in Sierra Leone, July 2024-June 2025

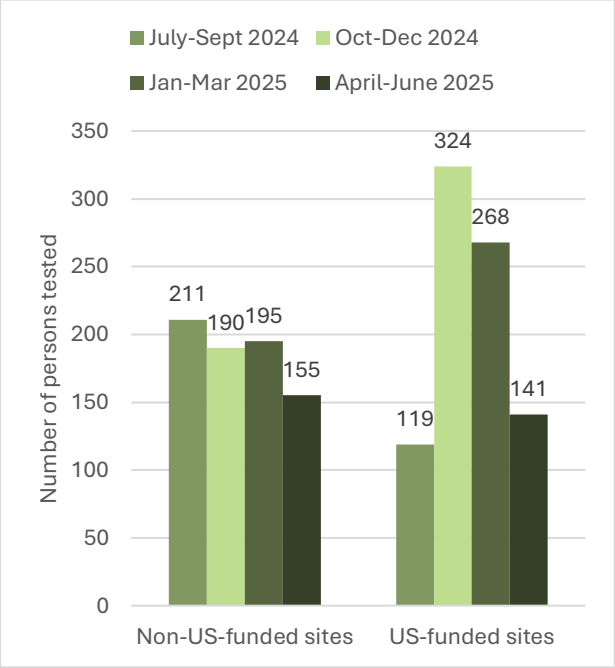
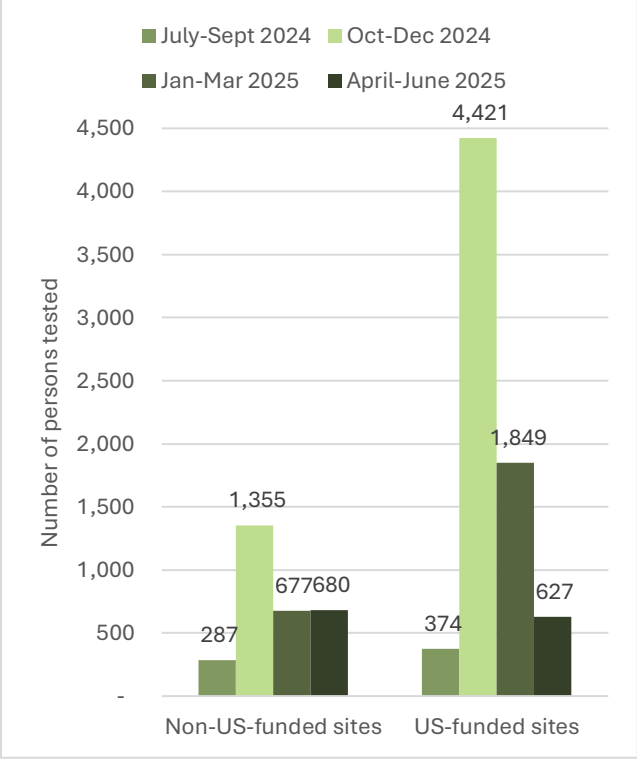


Figure 9: Viral load testing volumes by US funding status in Sierra Leone, July 2024-June 2025



The trends observed across the three countries likely represent only the early effects of the 2025 US funding cuts. As international assistance continues to contract, sustained community-led monitoring will be essential to document how these financial shifts affect service continuity, laboratory systems, and health outcomes of recipients of care over time, as well as how existing issues are further exacerbated by reduced funding.

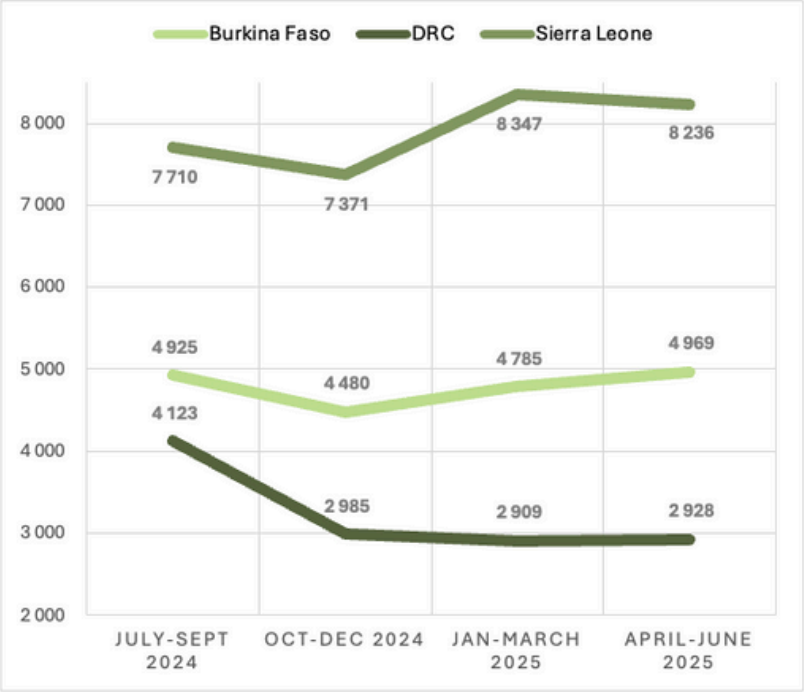
HIV TESTING

Based on the WHO recommendation to offer HIV testing at community-based facilities and healthcare facilities, the project focused on the number of HIV tests performed, whether self-testing options were offered, and the locations where testing was available.

All health facilities reported offering rapid and confirmatory HIV testing. Burkina Faso provided the widest scope of testing options, with HIV testing offered in public and private health centers and through NGOs, mobile testing sites, and peer educators. In contrast, HIV testing in the DRC remains generally confined to health facilities, with more limited community outreach. In Sierra Leone, HIV testing is available through a mix of public, private, and community-based sites, including mobile caravans and drop-in centers run by NGOs.

Overall, 63,768 HIV tests were performed over the reporting period across all three countries (see Figure 10). Burkina Faso performed 19,159 HIV tests, with a stable volume of between 4,500 and 5,000 tests per quarter.

Figure 10: Number of HIV tests performed (all countries)



The DRC performed 12,945 HIV tests. After a 28% drop from 4,123 in July-September 2024 to 2,985 in October-December 2024, testing volumes remained stable in 2025 at around 2,900 tests per quarter.

Sierra Leone performed 31,664 HIV tests, with an average of 7,540 tests per quarter in 2024, increasing to an average of 8,290 tests per quarter in 2025.

Access to HIV self-testing is very low; only 7,385 self-tests were performed across all three countries over the reporting period (see Figure 11). Overall, 42% (5/12) of the monitored health facilities surveyed in Burkina Faso, 50% (5/10) in the DRC, and 42% (5/12) in Sierra Leone do not offer HIV self-testing, primarily because of stockouts of self-test kits and a common perception that self-testing belongs exclusively under community outreach rather than under facility-based services.

Over the whole reporting period, Burkina Faso provided 310 self-tests, representing 2% (310/19159) of all HIV tests performed. The DRC provided 4,639 self-tests, which account for 25% (4,639/12,945) of all HIV tests performed. Most of the self-tests in the DRC (3,372/4,639) were provided through the Centre Convivial Matonge, a key population-friendly health facility. Sierra Leone provided 2,436 self-tests, representing 7% (2,436/31,664) of all HIV tests performed.

Across all three countries, the main challenge in maintaining HIV testing services was recurrent stockouts of test kits, largely caused by national-level procurement delays, under-delivery of quantities ordered by health facilities, and limited redistribution between districts, affecting between half and four-fifths of surveyed health facilities.

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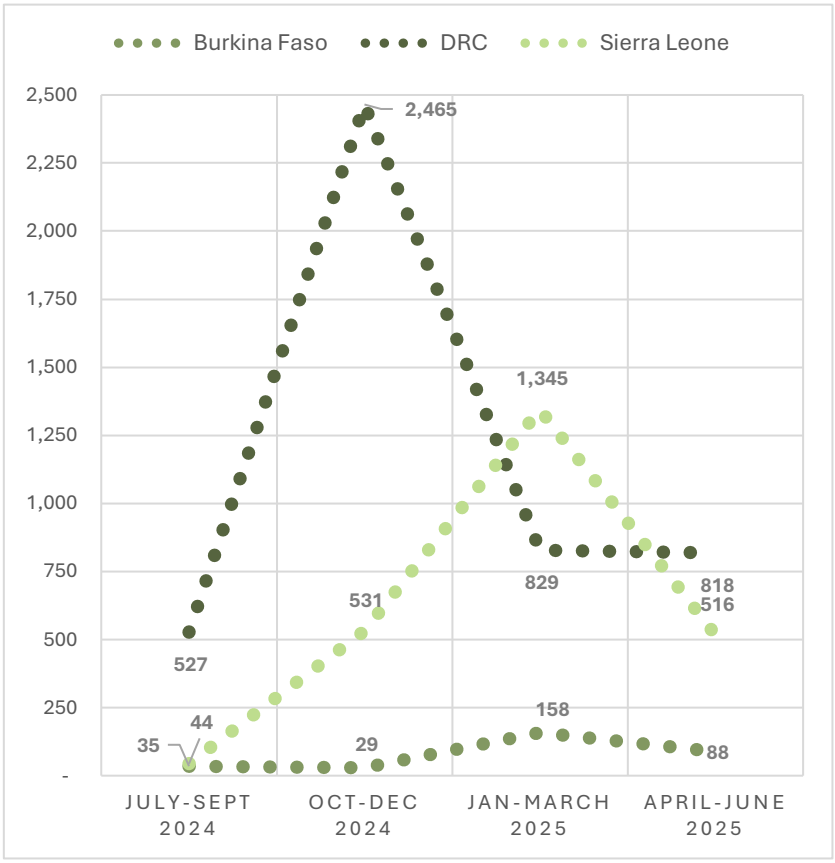
Figure 11: Number of HIV self-tests provided (all countries)



Across all three countries, the main challenge in maintaining HIV testing services was recurrent stockouts of test kits, largely caused by national-level procurement delays, under-delivery of quantities ordered by health facilities, and limited redistribution between districts, affecting between half and four-fifths of surveyed health facilities.

In Burkina Faso, 50% (6/12) of health facilities reported interruptions in supplies of Determine kits, self-tests, and Xpert HIV-1 Qual reagents. In the DRC, 60% (6/10) of facilities faced similar shortages. Notably, the DRC's national testing algorithm includes a third confirmatory test that cannot be performed due to prolonged stockouts.

In Sierra Leone, 80% (10/12) of healthcare centers reported shortages of HIV self and non-self-testing kits (including SD Bioline, Determine, Unigold, and HIV/Syphilis Duo kits). In addition to commodity shortages, a quarter of facilities in Sierra Leone reported that HIV testing rooms do not ensure adequate privacy or confidentiality, deterring individuals from getting tested.

These operational challenges that hinder access to HIV testing cause harmful outcomes in a country's response to HIV – it is likely that more people will present for testing with advanced HIV disease, endangering their lives and health and increasing HIV transmission.

Details of the types and average duration of stockouts and equipment malfunctions related to HIV testing, as well as the reasons for the stockouts, are set out in Annex 4.

EARLY INFANT DIAGNOSIS: NUCLEIC ACIDIC AMPLIFICATION TESTING

Standard HIV testing cannot determine whether an infant born to a woman living with HIV has acquired HIV since these tests detect antibodies and infants retain maternal antibodies for up to 18 months. Nucleic acidic amplification testing (NAATs) directly detects the virus itself, making it the only reliable method to confirm HIV in newborns. NAAT is, therefore, essential to ensuring successful prevention of vertical transmission and to treating any infant born with HIV. WHO recommends testing infants born to women living with HIV at four to six weeks of age.

All three countries' national guidelines are aligned with the WHO recommendations; however, data indicate that not all health facilities adhere to the four- to six-week window for NAAT. Across all countries, 91% (31/34) of the health facilities monitored provide EID services, 71% (22/31) of these offer point-of-care (POC) NAAT, and 61% (19/31) report providing NAAT at four to six weeks after birth. Table 2 details these results by country.

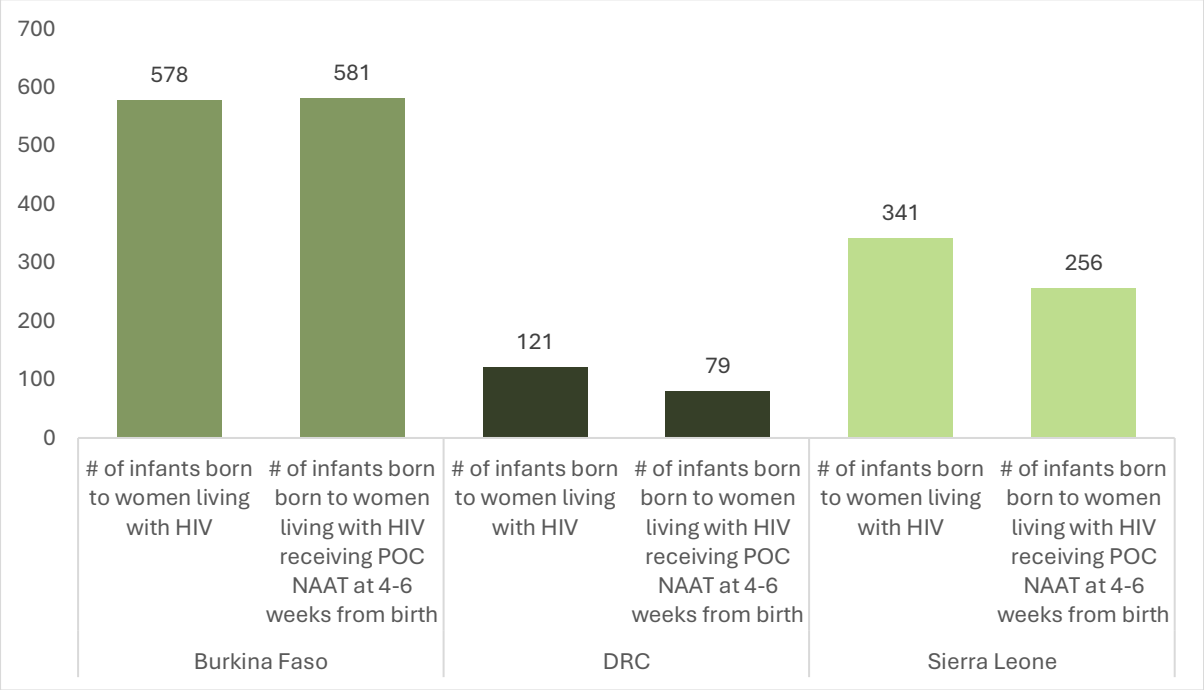
Table 2: EID implementation details per country

Country	Number of facilities monitored	Number of facilities providing EID	Number of facilities offering POC NAAT	Number of facilities reporting performing NAAT at 4-6 weeks after birth
Burkina Faso	12	12	11	10
DRC	10	8	4	5
Sierra Leone	12	11	7	4
TOTAL	34	31	22	19

The absence of POC technologies in 29% of health facilities and non-alignment with the window for NAAT in 39% of health facilities limit access to timely EID, which will drive delayed initiation of ART, increased loss to follow-up, and increased undetected HIV acquisitions, leading to higher infant mortality rates.

Figure 12 presents the total number of infants born to women living with HIV, and the total number of NAAT tests across all sites during the reporting period. There are variations between these two indicators because of the four- to six-week delay between birth and NAAT testing: some infants tested during the reporting period were born prior to July 2024, and some infants born in May-June 2025 will be tested only after the reporting period. Nevertheless, the figures provide useful insight into EID access across the three countries.

Figure 12: Number of infants born to women living with HIV and number of infants tested with NAAT at 4-6 weeks (by country)



In Burkina Faso, the number of infants born to women living with HIV recorded (578) and those tested for HIV (581) are almost equivalent, indicating high testing capacity. Two tertiary-level regional hospitals account for 65% (382/581) of EID tests performed during the reporting period: CHU Charles de Gaulle (266 tests) and CHU Yalgado (116 tests). Two facilities (primary-level site CMA Dafra and tertiary-level site CHU Sourou Sanou) did not report any EID tests during the reporting period.

In the DRC, 121 infants were born to women living with HIV and 79 NAAT tests were performed during the same period. While this suggests that EID services are functional, the gap between births and tests points to limitations in testing coverage.

In Sierra Leone, 341 infants born to women living with HIV and 256 NAAT tests were reported, which is the lowest coverage rate among the three countries. Facilities report limited laboratory infrastructure and refer samples to other centers for processing, which contributes to delays in result turnaround. The facilities equipped for POC NAAT report higher testing volumes. Secondary-level sites, such as Rokupa Government Hospital (147 tests) and Kenema Government Hospital (25 tests), and primary health facility Hastings CHC (54 tests) represent 88% (226/256) of NAAT performed during the reporting period. In contrast, several non-POC facilities, all secondary-level health facilities, reported no NAAT tests during the period (Bo Government Hospital, Lakka Government Hospital, and Lumley Hospital).

Across all three countries, healthcare workers consistently reported frequent stockouts of reagents and EID test supplies, equipment malfunctions, and delays in result turnaround. **Error! Reference source not found.** describes the type, duration, and reasons for disruptions to EID in Burkina Faso, the DRC, and Sierra Leone.

Table 3: EID challenges in Burkina Faso, DRC, and Sierra Leone

Theme	Burkina Faso	DRC	Sierra Leone
Stockouts of EID supplies	Frequent stockouts of reagents and incomplete dried blood spot (DBS) card supplies	Recurrent stockouts of EID test kits and reagents; irregular deliveries from central level	Frequent stockouts of EID testing supplies
Equipment functionality	GeneXpert and other machines regularly malfunction	Central laboratory bottlenecks affect processing; local equipment availability is inconsistent	Machine breakdowns require sending samples to other sites
Result turnaround time	Delays linked to stockouts and machine dysfunctions caused by lack of maintenance, memory card failure, and absence of a functioning inverter	One report (*Centre de Santé Polyclinique Light*) indicating up to 6 months' delay in receiving the results from the reference laboratory	Delays in diagnosis and treatment initiation due to malfunctioning equipment and sample referrals
Supply chain & logistics	Need for better forecasting and supply planning	Inconsistent delivery from central warehouse; unstable availability	Sample referral due to malfunctioning devices slows processing
Training & staff capacity	Need for training/refresher sessions on new reagents	Need for regular training on EID procedures and sample handling	Need for improved training on sample collection and result management
Follow-up systems	Need for specific registries for pediatric HIV follow-up; gaps in mother-child tracking	Weak tracking of sample flow and delayed feedback from labs	Missed appointments, late presentations, and home births weaken follow-up, a situation worsened by the loss of US support for community volunteers who are essential for outreach and RoC tracking

A more detailed analysis of stockouts and equipment malfunctions related to EID is presented in Annex 4.

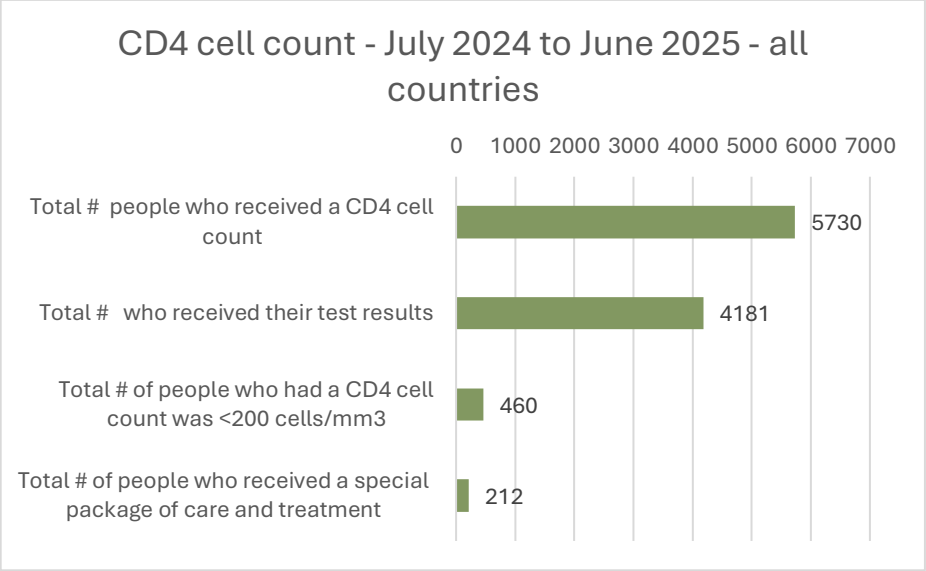
CD4 CELL COUNT

A CD4 cell count is the WHO-preferred test for identifying people with advanced HIV disease, who are vulnerable to serious illness and high mortality; they need a special package of care and treatment. CD4 cell count is recommended for people entering or re-entering HIV care and to support adherence counseling (if viral load is unsuppressed), to help diagnose opportunistic infections (if a person living with HIV is ill), and for deciding if a person living with HIV on stable ART can stop cotrimoxazole prophylaxis or fluconazole (for pre-emptive treatment or maintenance). Given the current funding uncertainties and risks of ARV rationing, CD4 testing remains indispensable for identifying RoCs requiring urgent care and for guiding ART initiation or reinitiation.

National guidelines in Burkina Faso state that a CD4 cell count should be performed when entering care, at six to 12 months after starting ART, and thereafter as indicated. However, community and health actors indicated that CD4 is no longer routinely performed as follow-up of

RoCs has shifted to viral load monitoring. In the DRC, CD4 cell count is performed when entering care, at six to 12 months after starting ART, and thereafter based on clinical stability. In Sierra Leone, CD4 cell count is performed when diagnosed with HIV (using POC technologies), for people living with HIV who are re-engaging in care or who are not virally suppressed, or every six months, if indicated (for people living with HIV-2, because there are no approved HIV-2 viral load tests).

Figure 13: CD4 cell count, July 2024-June 2025 (all countries)



Across the 34 health facilities monitored, 65% (22/34) offer CD4 cell count testing, and 73% of them (16/22) have POC capacity. CD4 POC testing provides same-day results, which enables prompt initiation of AHD care and treatment, especially since people cannot always come back quickly for their test results. In Burkina Faso, only four out of 12 sites perform CD4 testing – two secondary district hospitals and two tertiary regional hospitals – and all of them have POC capacity. In the DRC, six out of 10 facilities offer CD4 testing – five primary healthcare centers and one secondary district hospital. Three primary healthcare centers have CD4 POC testing capacity. Only Sierra Leone reports that all 12 health facilities offer CD4 cell count, and nine of them have POC capacity.

During the CLM for Laboratories pilot project, CD4 cell count monitoring was assessed by comparing the number of people eligible for the test, as per WHO guidelines, with those who received it and obtained their results. The project also tracked the proportion of RoCs with a CD4 count below 200 cells/mm^3 who received a special package of care and treatment for AHD. In low- and middle-income countries, nearly half of people living with HIV who have AHD have no symptoms, and only CD4 cell count testing will enable them to receive the special package of care and treatment required to prevent increased morbidity and mortality.

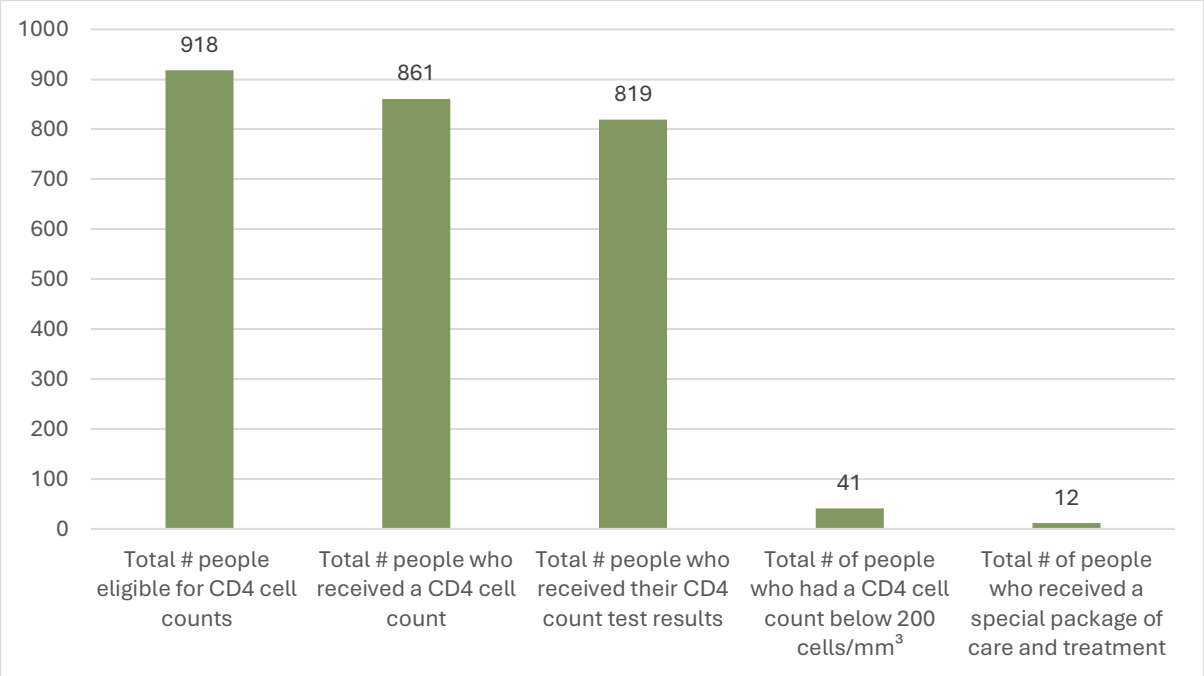
As illustrated in Figure 13, a total of 5,730 CD4 cell count tests were performed over the reporting period across the three countries. A total of 4,181 RoCs (73%) received their test results; 460 RoCs (11%) had a CD4 cell count below 200 cells/mm^3. Of RoCs needing a special package of care and treatment, only 46% (212/460) received it.

In Burkina Faso, CD4 testing data were available only from three health facilities, and data from these sites were often incomplete due to documentation gaps. However, the available data from the three health facilities does show a 76% decline in the number of CD4 cell count tests performed, from 1,551 in July-September 2024 to 371 in April-June 2025. Persistent reagent shortages further constrain service delivery. No data were available on the provision of a special package of care and treatment for individuals with AHD (CD4 <200 cells/mm^3), limiting interpretation of national trends.

Feedback from RoCs indicates that more than one-third (51/152) of respondents were unaware of what a CD4 cell count measures. Among the 152 RoCs interviewed, 68% (104/152) reported having had a CD4 test – most commonly at the time of HIV diagnosis (73% – 76/104). Among the 104 RoCs who reported having done a CD4 test, 48% (50/104) received their results within two weeks, indicating delays in result turnaround for over half of users. Nonetheless, 63% (65/104) reported receiving their results during routine visits, and 73% (76/104) reported that their test outcomes were explained, suggesting that provider communication remains relatively strong despite service limitations.

In the DRC, CD4 testing is largely non-functional due to chronic reagent shortages and prolonged equipment breakdowns. Quantitative data were available from only two of the 10 facilities monitored: primary healthcare center Dream and secondary district hospital CSR Vijana. As illustrated in Figure 14, in these sites, 94% (861/918) of eligible RoCs received a CD4 test and 95% (819/861) obtained their results, but only 29% (12/41) of those with CD4 counts below 200 cells/mm^3 received a special package of care and treatment, reflecting weak clinical management of advanced HIV disease.

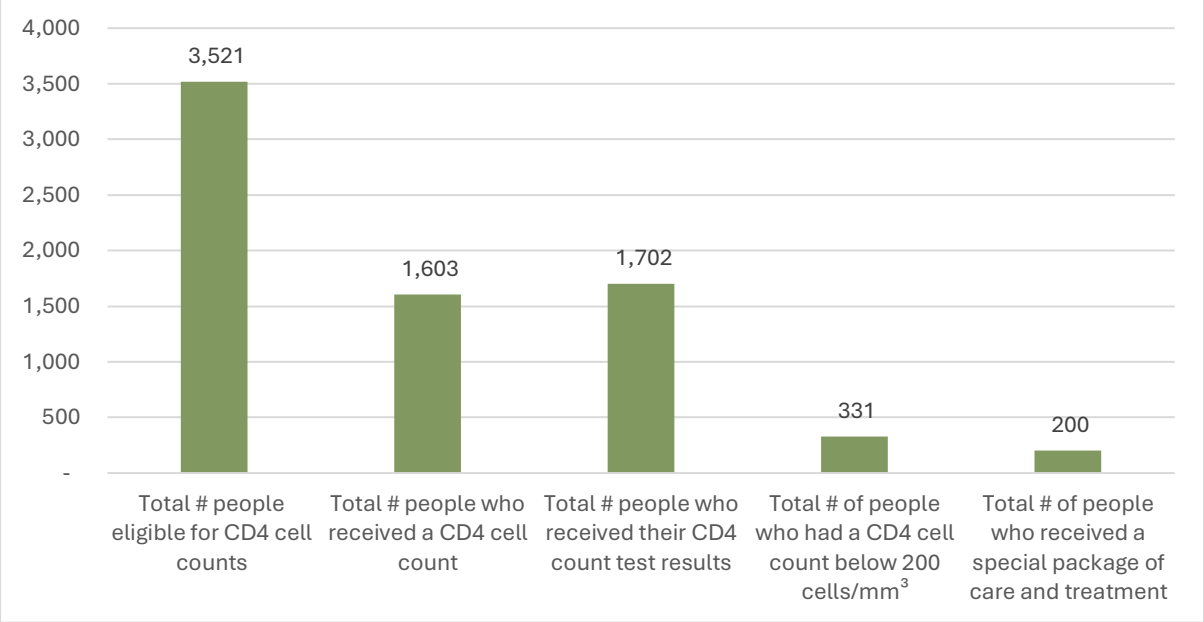
Figure 14: CD4 cell count in DRC, July 2024-June 2025



Among the 111 RoCs interviewed in the DRC, 45% (50/111) reported having had a CD4 test, mostly at the time of HIV diagnosis. In total, 60% (30/50) said they received explanations about the purpose and results of the test, but half (25/50) waited more than two weeks for their results. Combined with barriers, such as transport costs and distance to facilities, these findings point to irregular access and inefficiencies in result management that compromise the usefulness of CD4 monitoring.

In Sierra Leone, as illustrated in Figure 15, only 48% (1,603/3,521) of eligible individuals received a test and their results. This is mainly due to systemic supply-chain challenges. Despite these constraints, 60% (200/331) of people with CD4 counts below 200 cells/mm^3 received a special package of care and treatment, representing the strongest clinical continuity among the three countries.

Figure 15: CD4 cell count in Sierra Leone, July 2024-June 2025



Awareness of CD4 testing among the 218 RoCs interviewed is high in Sierra Leone: two-thirds (144/218) knew what a CD4 test measures, and 80% (175/218) had undergone testing. Some 85% (148/175) were tested at diagnosis, and 64% (112/175) had their most recent CD4 test within the past 18 months. Turnaround time was relatively efficient, with 82% (143/175) receiving their results the same day, and 90% (157/175) confirming that results were explained by a healthcare provider. The main barrier, cited by 60% (105/175) of respondents, was the cost and difficulty of traveling to health facilities, highlighting ongoing access challenges despite strong service awareness and provider engagement.

Stockouts and equipment malfunctions continued to affect CD4 testing across countries, reflecting weak supply-chain management and limited maintenance systems that compromise AHD services. In the DRC and in Sierra Leone, one-third of facilities offering CD4 testing were out of stock of the supplies to provide point-of-care CD4 testing. There were no stockouts reported in Burkina Faso, but this could be due to a lack of information on the subject as CD4 is no longer a nationally monitored indicator. The details of the types and average duration of stockouts and equipment malfunctions related to CD4 cell count testing and the reasons are set out in Annex 4.

VIRAL LOAD MONITORING

Viral load (VL) monitoring is used to assess response to antiretroviral treatment. The goal of HIV treatment is an undetectable/suppressed viral load, which improves quality of life, health, and survival among people living with HIV and can eliminate or greatly reduce the chance of vertical and sexual transmission. Viral load monitoring detects treatment failure, guides timely clinical decisions, and is central to ensuring that people living with HIV are supported to maintain viral suppression and that they receive effective ART.

WHO recommends monitoring viral load at six and 12 months after ART initiation and yearly thereafter, and to take appropriate action based on results. National guidelines from all three countries are aligned with WHO recommendations.

Across all countries, 88% (30/34) of the monitored health facilities provide viral load monitoring. All 12 health facilities in Burkina Faso and all 12 facilities in Sierra Leone provide viral load monitoring either on site or through sample referral systems. In the DRC, six of the 10 facilities assessed offer VL monitoring – five primary healthcare sites and one secondary district hospital.

POC capacity is available in 60% (18/30) of health facilities across all countries. Burkina Faso has VL POC monitoring in nine of 12 facilities (75%) – in one primary healthcare site, seven secondary district hospitals, and one tertiary regional hospital. The DRC has VL POC capacity in three primary healthcare sites of the six facilities offering VL monitoring (50%). Sierra Leone has VL POC monitoring in six of 12 facilities (50%) – in one primary healthcare site and five secondary district hospitals. **Error! Reference source not found.**4 gives a snapshot of the main VL monitoring results reported by health facilities over the reporting period.

Table 4: Comparative summary of VL monitoring results, July 2024-June 2025

Country	% of eligible people living with HIV who received a VL test	% of people living with HIV who received test results within 2 weeks	Number of people living with HIV with a detectable VL	% of people living with HIV with a detectable VL who received enhanced adherence counseling and repeat test
Burkina Faso	100%[7]	42%	6,010	10%
DRC	90%	54%	188	65%
Sierra Leone	77%	38%	804	49%

While coverage among eligible RoCs is relatively high, the main challenge lies in the timeliness of result delivery. Delays in the return of viral load results were observed in all countries. Qualitative interviews with HCWs reported that these delays are linked to referral processes, reagent shortages, and equipment malfunctions.

Healthcare workers across all three countries consistently reported that the purpose of viral load monitoring and results are explained to RoCs and that enhanced adherence counseling, followed by repeat testing, is systematically offered in cases of detectable VL; however, the quantitative results show a gap in linkage to care for RoCs with a detectable VL. As illustrated in Table 4, in the DRC, 65% (122/188) of people living with HIV with a detectable viral load received enhanced adherence counseling and a repeat test; in Sierra Leone, this proportion is 49% (395/804); and in Burkina Faso, this proportion is only 10% (624/6010).

Further consultations with country partners indicated that limited access to repeat viral load testing and adherence counseling is driven by several factors, including RoCs not perceiving the need for additional services when they feel clinically well and persistent barriers to accessing care more broadly, such as fear of stigma and discrimination and social or religious pressures. RoCs in all countries also reported that transport costs, long distances, long waiting times and repeated visits to collect results were among the most common difficulties faced for VL monitoring. If these barriers are not systematically addressed, countries risk rising HIV transmission, increased treatment failure and drug resistance, a higher burden of advanced HIV disease, and ultimately poorer health outcomes for RoCs, reflected in reduced quality of life and increased morbidity and mortality.

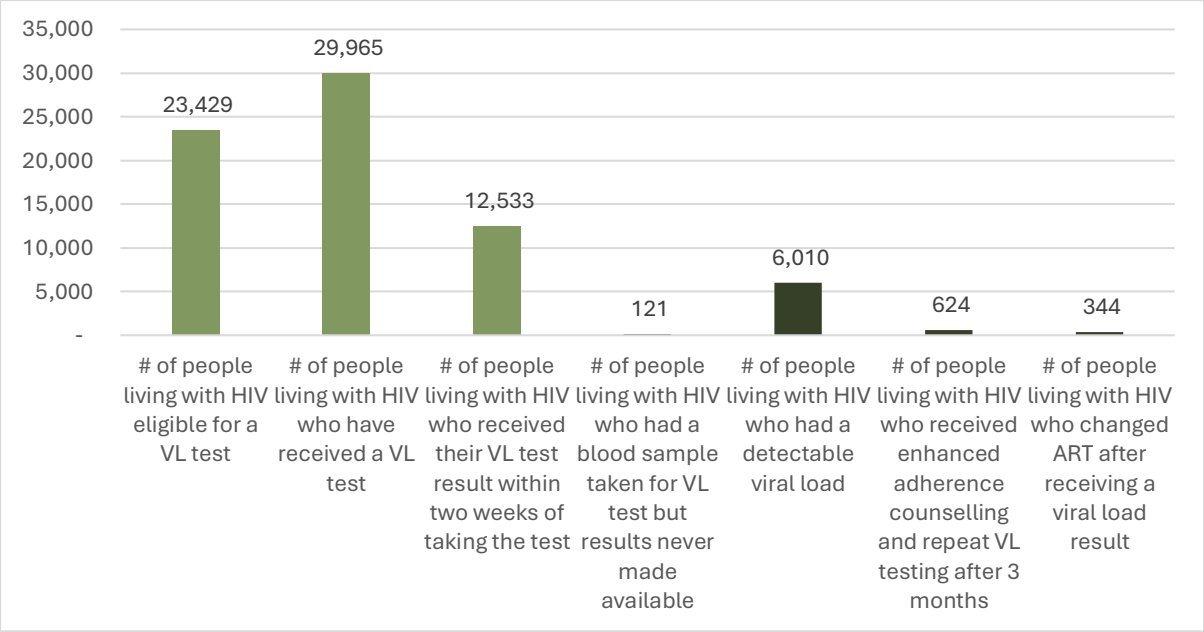
[7] Data collected shows 127% coverage. However, considering that people living with HIV eligible for the test before the reporting period were most probably tested during the reporting period, the coverage has been capped at 100%.

From the RoC perspective, understanding of viral load monitoring also appears relatively high but varies across countries: in Burkina Faso, 94% of RoCs (143/152) reported knowing what viral load is; in the DRC, this was the case for 86% of RoCs (96/111); and in Sierra Leone, this was true for 62% (136/218) of RoCs.

In Burkina Faso, viral load monitoring is strong at the testing stage, with facilities reporting an average turnaround time of around 11 days. However, while one-third of the 129 RoCs interviewed who did a VL test reported receiving their viral load results within two weeks (50/129) in line with the expected standard, 44% (56/129) waited longer, including nearly a quarter who waited over three months (32/129). In addition, 19% (24/129) of RoCs said that they did not remember when they received their results, suggesting that tests may have been performed too long ago or that post-test communication is inconsistent. Although general awareness of viral load monitoring is high, a small minority (6% – 9/152) indicated not knowing what it was, pointing to the need for continued education of RoCs to reinforce understanding of VL in treatment monitoring.

As illustrated in Figure 16, among those receiving a VL test in Burkina Faso, 42% (12,533/29,965) received their test results within two weeks. Healthcare workers attributed delays and inconsistencies to fluctuating reagent availability, intermittent equipment functionality, and logistical bottlenecks affecting result return. Among those tested, 20% had a detectable viral load (6,010/29,965), but only 10% (624/6,010) received enhanced adherence counseling and repeat testing. These figures indicate limited clinical reactivity and underutilization of viral load data to guide management of cases of unsuppressed viral load.

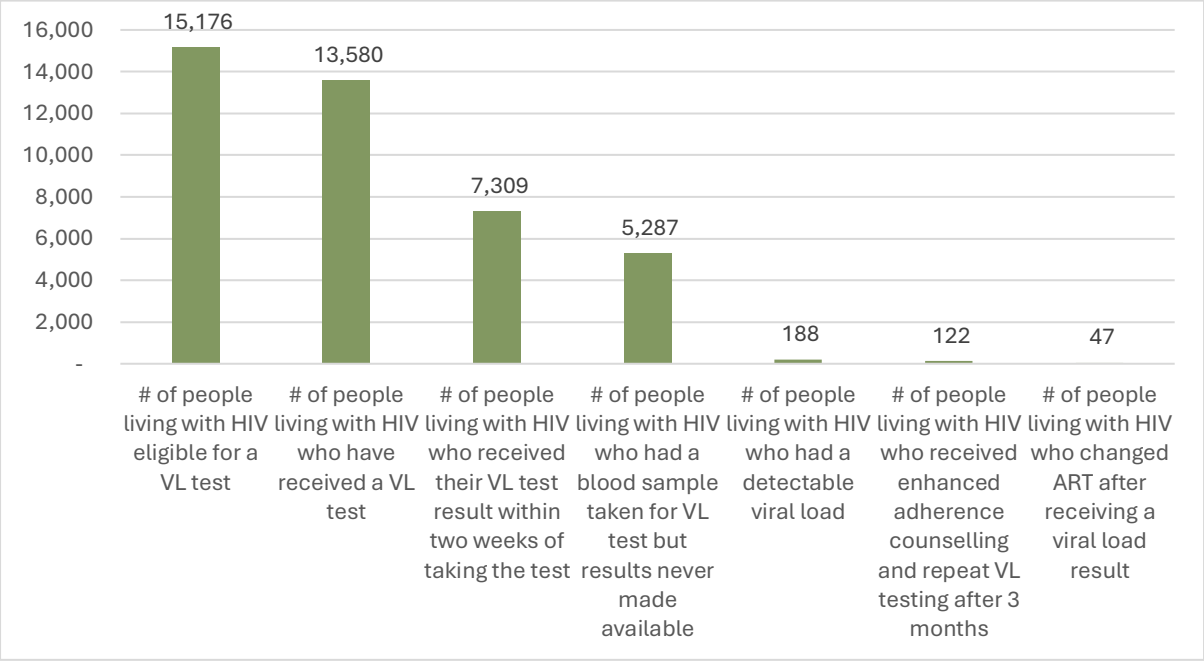
Figure 16: Viral load monitoring in Burkina Faso, July 2024-June 2025



In the DRC, as illustrated in Figure 17, coverage of VL monitoring among eligible RoCs reached nearly 90% (13,580/15,176), reflecting strong uptake at the testing stage. However, weaknesses in result management and clinical follow-up were noted. Only 54% (7,309/15,176) of those tested received their viral load results within two weeks, while 35% (5,287/15,176) never received them at all – a considerable loss of information that limits the usefulness of testing for treatment monitoring. Healthcare workers attributed these challenges to recurrent supply and transport disruptions, the absence of on-site testing, and long turnaround times from reference laboratories.

Awareness of viral load monitoring in the DRC is generally high, though 14% (15/111) of RoCs reported not knowing what the test measures, pointing to a communication gap that may limit RoC understanding and engagement in treatment monitoring. The proportion of people with a detectable viral load remains low (1.4% – 188/13,580), and 65% (122/188) of them received enhanced adherence counseling, the highest rate of follow-up support among the three countries.

Figure 17: Viral load monitoring in DRC, July 2024-June 2025

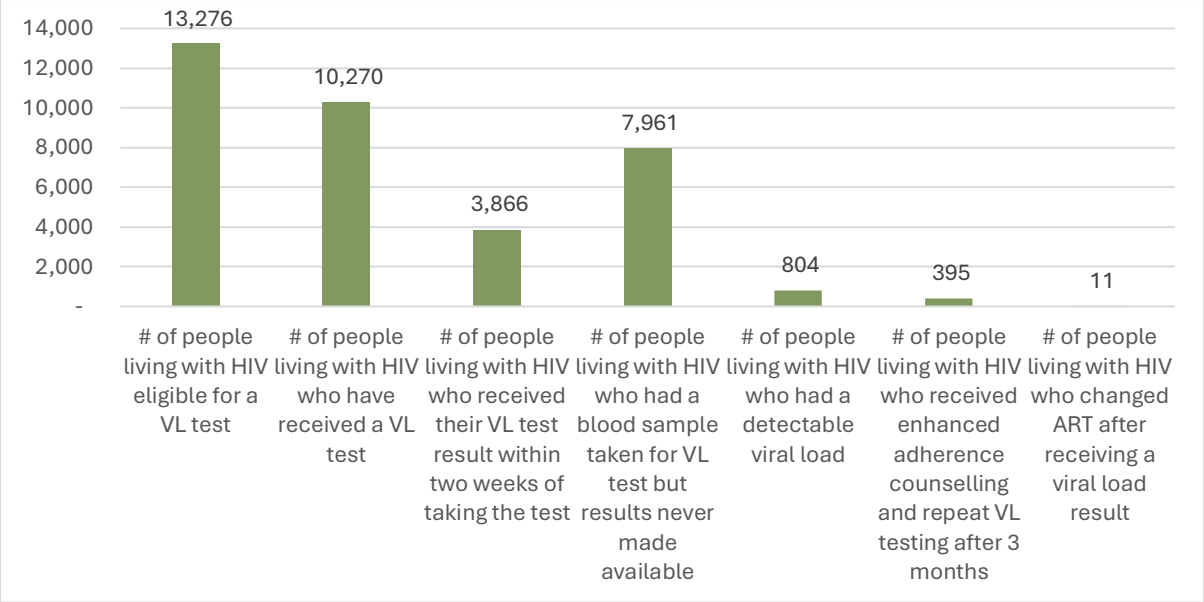


In Sierra Leone, as illustrated in Figure 18, among 13,276 people eligible, 77% (10,270) received a viral load test, which is the lowest rate of coverage among the three countries. Of these, 38% (3,866/10,270) obtained their results within two weeks, while 77% (7,961/10,270) of the total tests performed had results that were either delayed or never made available to RoCs.[8] Healthcare workers linked these delays and gaps to the absence of point-of-care testing, the centralization of laboratory services, and the logistical challenges associated with transporting samples and communicating results.

Awareness of viral load monitoring is comparatively low, with nearly 40% (83/218) of RoCs interviewed reporting that they did not know what the test was, suggesting weak RoC counseling and communication around its purpose and implications. Clinical data show that 49% (395/804) of those with a detectable VL received enhanced adherence counseling and repeat testing.

[8] *The apparent discrepancy between proportions may be partly due to the inclusion of results from samples collected before the reporting period, which were still being processed during the reporting time frame.*

Figure 18: Viral load monitoring in Sierra Leone, July 2024-June 2025



Stockouts of viral load-related supplies and equipment malfunctions disrupted viral load monitoring across all countries. The types and average duration of stockouts and machine malfunctions related to viral load monitoring, as well as their underlying causes, are detailed in Annex 4.

TUBERCULOSIS SCREENING

People living with HIV are up to 22 times more likely to fall ill from TB than HIV-negative people. TB is the most common illness and a leading cause of death among people living with HIV. According to WHO, in 2023, 161,000 people living with HIV died from TB, which is preventable and treatable.[9] Diagnosing and treating TB in people living with HIV, especially early – before treatment costs become catastrophic – saves lives and prevents transmission. WHO recommends that all people living with HIV be screened for the four classic symptoms (cough, fever, weight loss, and night sweats) at every visit.

TB screening is generally integrated into routine HIV care in all three countries, with RoCs reporting that providers usually ask about TB symptoms during routine visits. However, the regularity of these screenings differs from one facility to another. Data analysis did not find any trends in consistency of TB screening related to the level of health facility or whether the site was US-funded or not.

In Burkina Faso, 70% of RoCs (106/152) reported always being asked about TB symptoms during each healthcare visit, while 4% (6/152) said that they were asked regularly,16% (25/152) sometimes, 4% (6/152) rarely, and 5% (7/152) never (see Figure 19). Screening consistency varied between secondary-level district hospitals. Up to 90-100% of respondents indicated systematic questioning in CHR Gaoua (11/11), CHR Banfora (10/11), and CHR Tenkodogo (9/10). However, in CHR Koudougou, only 17% (2/12) of RoCs reported being always asked about their symptoms, as did 42% (5/12) in CHR Dédougou. According to the implementing partner, RAME, a significant number of RoCs, particularly in tertiary-level regional hospitals, such as CHU Yalgado and CHU Charles de Gaulle, expressed limited knowledge about tuberculosis and its prevalence and severity among people living with HIV.

[9] https://iris.who.int/server/api/core/bitstreams/7292c91e-ffb0-4cef-ac39-0200f06961ea/content

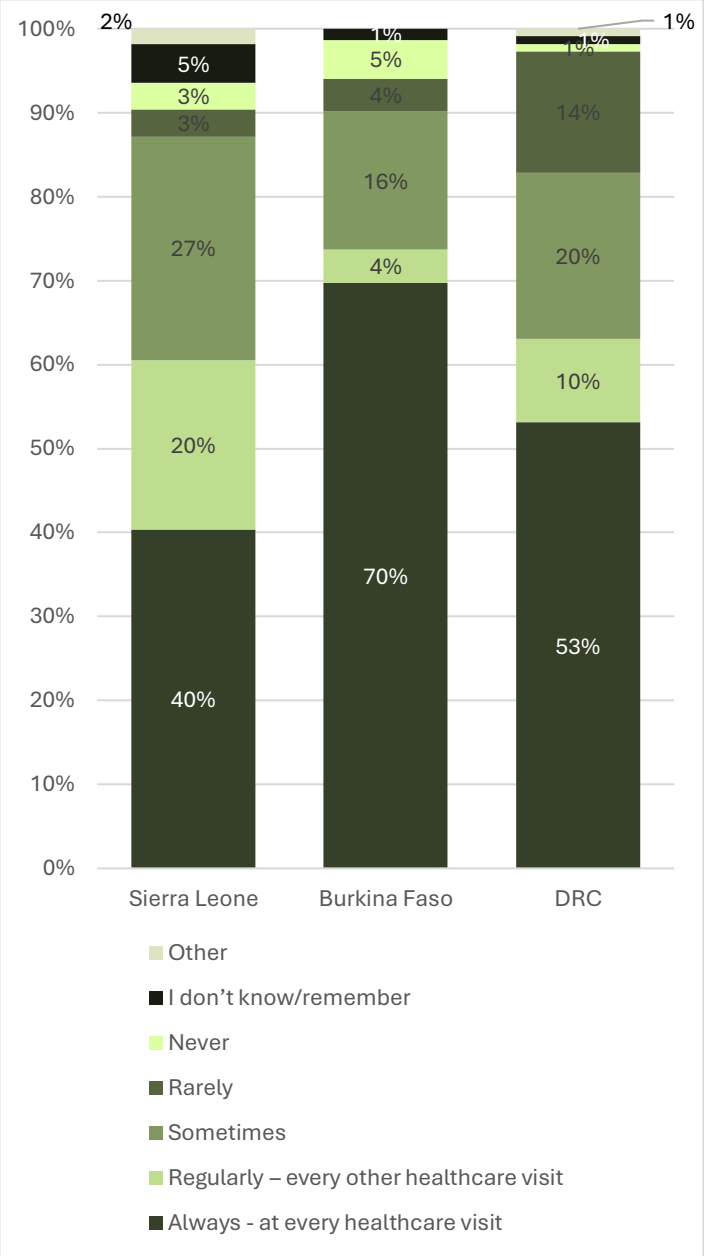
Qualitative data also indicate that TB screening is not systematic. One RoC explained that screening used to be carried out by an organization that had not visited the site for the past two years.

In the DRC, community feedback shows inconsistent TB screening: 53% of RoCs (59/111) reported always being asked about TB sy mptoms at every healthcare visit, while 10% (11/111) said regularly, 20% (22/111) sometimes, 14% (16/111) rarely, and 1% (1/111) never.

RoCs reported systematic screening at facilities such as primary-level Asodeki Convivial Centre (100% – 9/9) and secondary-level Boyambi General Reference Hospital (94% – 15/16). Screening consistency appears to be lower in the following primary health facilities: at Centre Hospitalier DREAM, no respondent (0/10) reported being always screened and 70% reported being screened sometimes (7/10); and at Centre Convivial IST Matonge, 40% (4/10) reported sometimes, 30% (3/10) rarely, and none (0/10) always.

In Sierra Leone, out of 218 RoCs interviewed, 40% (88/218) reported always being asked about TB symptoms at every visit and 20% (44/218) regularly, while 27% (58/218) said sometimes, 3% (7/218) rarely, and 3% (7/218) never.

Figure 19: Frequency of TB symptom screening among RoC (by country)



The data analysis highlights disparities between facilities despite them all being secondary district-level hospitals. Screening appears consistent at sites such as Bo Government Hospital and Moyamba Government Hospital, where 95-100% of RoCs reported being systematically asked about TB symptoms. In contrast, Lumley Government Hospital shows a much lower level of systematic screening, with only 5% (2/40) of RoCs reporting that they are always asked about TB symptoms.

IMPLEMENTATION OF COMMUNITY-LED ADVOCACY

Community-led monitoring across Burkina Faso, the DRC and Sierra Leone revealed consistent systemic weaknesses in diagnostic and laboratory services that directly affect the quality of HIV care. The most common issues were frequent stockouts of testing reagents and consumables, recurrent breakdowns of key laboratory equipment, and delays in the return of test results, particularly viral load and early infant diagnosis. These operational gaps not only compromise timely clinical decision-making, but also erode the confidence of recipients of care in the health system, leading to increased morbidity and mortality among people living with and vulnerable to HIV.

In all three countries, the CLM findings provided evidence for advocacy targeting both national and provincial decision-makers. Across contexts, country partners collaborated with other members of civil society, using CLM data to demonstrate that the challenges observed at facility level were rooted in weaknesses in national supply chain management, limited maintenance of laboratory equipment, and insufficient oversight of result management systems. The data also highlighted broader socioeconomic challenges to accessing the HIV-related diagnostics, including the financial and logistical barriers faced by RoCs, especially in rural or peri-urban areas, who must travel long distances and incur indirect transport costs to access testing sites.

Advocacy efforts built on this evidence have led to tangible progress. Through national dialogues, multistakeholder workshops, and strategic engagement with ministries of health and Global Fund principal recipients, civil society networks were able to trigger concrete commitments to strengthen procurement planning, reinforce maintenance systems, and institutionalize regular communication between government and community actors. **Error! Reference source not found.**5 details the immediate outcomes of the advocacy actions.

Table 5: Impact of CLM advocacy actions on diagnostic and laboratory services

COUNTRY	OUTCOMES OF ADVOCACY
Burkina Faso	Capacity building of 36 focal points enabled them to initiate advocacy with local authorities among the monitored health facilities, resulting in site-level outcomes, for example: o Emergency provision of NAAT tests took place in the Tenkodogo Hospital. o Formal commitments were made by the Director of Fada Hospital to resolve issues around HIV testing and VL monitoring, and joint advocacy was conducted by the hospital director and implementing partner, targeting national authorities. o The framework to exchange around CLM findings in Fada Hospital was reinitiated. Following alerts on stockouts being escalated to national authorities and a national workshop with health facilities and district and national representatives, a set of recommendations was developed to address the dysfunctions highlighted by the CLM findings.
DRC	With advocacy pressure from the implementing partner and civil society partners, the following outcomes were documented: o Civil society stakeholders were invited to a two-day workshop to assess the procurement system for HIV in the DRC. o A procurement and distribution plan was developed during the workshop.

	○ Training of healthcare workers in VL monitoring started. ○ Recruitment of transporters for the dispatching of samples was initiated. ○ Quarterly meetings between the principal recipients and civil society stakeholders have been planned to monitor stockout issues.
Sierra Leone	Following an advocacy meeting with the National AIDS Control Programme, the Ministry of Health, civil society partners, and RoCs, national authorities committed to escalating the dysfunctions with the procurement and distribution system to higher government level.

In Burkina Faso, community data revealed that laboratory functionality was undermined by chronic stockouts, equipment failures, and long waiting times for test results. Building on this evidence, RAME and local focal points coordinated a structured advocacy process involving district, regional, and central authorities. Capacity-building sessions for community actors enabled them to engage directly with local health authorities, while alerts were escalated to national programs and the central medical store. This culminated in a national stakeholder meeting that brought together more than 45 representatives from the Ministry of Health, the Country Coordinating Mechanism, and civil society organizations. The discussions led to commitments to improve coordination between supply chain entities, strengthen early warning mechanisms for stockouts, and ensure the continuity of testing and viral load monitoring services. The process also reinforced recognition of CLM as a credible tool for identifying and resolving operational gaps in real time.

In the DRC, the CLM data exposed widespread national shortages of laboratory reagents and diagnostic kits, including the total absence of the third confirmatory HIV test. UCOP+, together with civil society partners, used these findings to engage the National AIDS Control Programme and the Global Fund principal recipient. After advocacy pressure that included plans for public communication and legal action, national authorities convened an urgent two-day workshop to review the supply of HIV-related commodities and supplies. The meeting resulted in the development of a national procurement and distribution plan. It also kick-started the training of healthcare workers in VL monitoring and the recruitment of transporters to improve the flow of reagents and samples. Quarterly meetings between civil society and principal recipients are planned to monitor implementation and prevent future stockouts.

In Sierra Leone, CLM highlighted gaps in the reliability and timeliness of diagnostic services, including frequent shortages of test kits and reagents, prolonged delays in the return of viral load results, and poor maintenance of equipment. Using these findings, the Network of HIV Positives in Sierra Leone (NETHIPS) engaged the National AIDS Control Programme and development partners to address weaknesses in procurement and distribution, advocate for established turnaround time standards, and improve community feedback mechanisms on result delivery. These discussions have increased institutional awareness of systemic challenges and are informing the escalation of these issues to higher government levels. Continued advocacy is focused on restoring stable community outreach and follow-up systems that were weakened by funding interruptions, and on strengthening accountability for laboratory services.

Across the three countries, advocacy informed by CLM findings has demonstrated its effectiveness in transforming data into action. The emerging improvements illustrate how CLM strengthens accountability and contributes to the progressive realization of accessible, reliable, high-quality HIV diagnostic and laboratory services.

CONCLUSION

The findings of the CLM for diagnostic and laboratory indicators pilot project highlighted persistent structural vulnerabilities within HIV systems across Burkina Faso, the DRC, and Sierra Leone, undermining the continuity, timeliness, and quality of essential HIV diagnostic services for recipients of care. Limited access to core HIV diagnostics, laboratory, and screening services undermines the right to health and leads to suboptimal treatment outcomes, poorer quality of life, and increased morbidity and mortality among people vulnerable to or living with HIV.

Finding 1:
The 2025 US funding cuts exposed donor dependence for core functions and disrupted fragile procurement systems.
The 2025 US funding cuts exposed systemic dependencies on external assistance, particularly in countries where key diagnostic services are concentrated within US-funded sites, underscoring how financial shocks can quickly destabilize laboratory services in systems dependent on donor funding.

Finding 2:
Stockouts and equipment malfunctions are the main disruptors of diagnostic and laboratory service continuity.
Across all three countries, stockouts and equipment malfunctions emerged as the principal disruptors of diagnostic and laboratory services. These operational weaknesses collectively hinder timely diagnosis, delay treatment decisions, and erode the confidence of RoCs in laboratory services.

Finding 3:
Results of viral load testing are delayed and clinical management is weak.
While VL monitoring is broadly available, result management and clinical follow-up remain weak. Coverage of VL monitoring was high in all three countries, but turnaround times were consistently delayed, with low proportions of RoCs receiving results within two weeks. Result delivery bottlenecks, exacerbated by supply shortages, reduce the clinical usefulness of viral load monitoring. In the DRC, 35% (5,287/15,176) of recipients never received their test results. Across all countries, enhanced adherence counseling following a detectable viral load was inconsistently provided, especially in Burkina Faso, where only 10% (624/6,010) of RoCs in need received appropriate follow-up. While the provision of these services may be underreported due to weak documentation at health facility level, there is a need to gather further in-depth data on the barriers to people living with HIV accessing the appropriate care.

Finding 4:
CD4 cell count testing is underprioritized, especially in Burkina Faso and the DRC, undermining continuity of advanced HIV care.
CD4 cell count testing remains underprioritized in national programs, especially in Burkina Faso and the DRC, where service functionality is low or inconsistent. In Burkina Faso, CD4 testing is no longer routinely conducted in HIV monitoring among RoCs, and in the DRC, only 29% (12/41) of interviewed people living with HIV with CD4 counts below 200 cells/mm^3 received appropriate care, reflecting a gap in the management of advanced HIV disease. Sierra Leone has a relatively stronger model, with broader availability of CD4 testing, better RoC awareness, and faster result turnaround. Nonetheless, stockouts of testing reagents and equipment malfunctions continue to limit continuity of care. As international funding is falling and supply challenges persist, the sustainability of CD4 monitoring as a clinical safeguard for advanced HIV disease and/or for ART initiation remains uncertain.

Finding 5:
Differentiated service delivery models are key to introducing new HIV tools.
Most of the self-tests in the DRC (73% – 3,372/4,639) were offered through the Centre Convivial Matonge, a key-population-friendly health facility. Similarly, in Sierra Leone, 77% (1,878/2,436) of self-tests were provided in three health centers (Hastings Community Center, Rokupa Hospital, and Port Loko Hospital), which have models based on strong community involvement in service delivery through community experts and volunteers. This highlights the role of differentiated service delivery models, a people-centered approach that adapts HIV services to serve the needs of RoCs, and of introducing new tools, such as HIV self-testing. Having a supportive environment encourages uptake of these new tools and ensures that the benefits of self-testing translate into prevention and treatment outcomes.

The preliminary results of the pilot project: *(Community Data in Action: Community-Led Monitoring for Diagnostic and Laboratory Services: Preliminary Results)* were shared at the 8th LabCoP Annual Meeting, "Strengthening Laboratory Systems and Networks: Sustaining Laboratory Gains in Challenging Times" (Nairobi, Kenya, October 2025). During the meeting, the critical role of community engagement in identifying gaps in HIV diagnostics, particularly in light of the recent US funding cuts, was recognized. The need to accelerate community engagement was also re-emphasized. Overall, these findings demonstrate that the resilience of HIV diagnostic and laboratory systems in the three countries remains fragile. CLM played a role in identifying these weaknesses and in catalyzing change. By generating credible evidence, CLM empowered communities to hold national authorities accountable, improve procurement coordination, and advocate for more responsive laboratory systems.

RECOMMENDATIONS

The recommendations emerging from the analysis made by the implementing partners emphasize strengthening national systems for laboratory and diagnostic services through improved supply management, equipment maintenance, counseling, and documentation.

In **Burkina Faso**, RAME identified that the major gaps were stockouts of reagents and equipment failures, long delays in result return, inconsistent counseling practices, financial and geographic barriers despite free services, stigma, and limited understanding of tests among recipients of care. RAME recommends:

- **Strengthening the supply chain** through the establishment of a national forecasting and response mechanism, including safety stocks for reagents and consumables
- **Programming regular equipment maintenance**, with a dedicated budget for preventive and corrective servicing, ensuring access to spare parts, inverters, and functional air-conditioning systems
- **Improving counseling and information for RoCs** by enhancing the communication skills of health workers so that RoCs understand the purpose and results of their tests, thereby supporting better adherence
- **Reinforcing community mechanisms** for the return of viral load results to users

In the **DRC**, the findings show that diagnostic and laboratory services have been negatively affected by prolonged stockouts of reagents, long result turnaround times, and transport barriers. Communities recommend:

- That **national programs** assume full ownership and oversight of all procurement and supply processes, including placing and following up on orders, rather than relying on external partners
- That national authorities **monitor distribution to the last mile**, ensuring that commodities reach health facilities in a timely manner
- That **civil society organizations continue applying CLM** to amplify the voices of RoCs and document service disruptions
- That **technical and financial partners** maintain their support to sustain life-saving services and stabilize the HIV response

In **Sierra Leone**, communities recommend practical actions to address recurrent stockouts, delays, and data gaps across HIV testing, EID, CD4, and viral load monitoring. These are:

- Expanding access to HIV self-testing beyond the PrEP program to reach a wider population
- Strengthening the national supply chain to prevent interruptions in HIV and EID testing commodities and to reduce delays for facilities dependent on central supply
- Increasing point-of-care testing capacity for early infant diagnosis to reduce waiting times and the need for referrals to other facilities
- Improving documentation and record-keeping to ensure that RoCs with low CD4 counts or unsuppressed viral loads are correctly identified and receive appropriate follow-up care
- Reinforcing logistics and turnaround systems for viral load monitoring to ensure timely delivery of results and faster clinical decision-making

In addition to each country focusing on its specific gaps, the CLM activities would benefit from including more granular monitoring of the full diagnostic cascade. For example, based on the results of the pilot project, countries should collect data on HIV testing, detailed by rapid testing, self-testing and confirmatory testing to hold duty bearers accountable regarding alignment to national protocols. This is especially important for the DRC, where facilities cannot perform the third confirmatory test due to lack of supplies. CLM activities should also focus on reasons for the barriers to accessing the additional care needed following essential HIV diagnostic tests, and what should happen to ensure consistent screening of people living with HIV for TB.

Implementing these recommendations will require sustained political commitment, increased domestic investment, and the integration of community-generated evidence into national planning. The implementing partners have already incorporated these priorities into their ongoing advocacy agendas, ensuring continued engagement with national authorities to address the identified gaps. Institutionalizing CLM as a routine exercise in national monitoring systems would ensure that data on the Availability, Accessibility, Acceptability, and Quality of laboratory services are continuously available.

As Burkina Faso, the DRC, and Sierra Leone work to strengthen their laboratory systems, community engagement remains vital to ensuring accountability and service quality. Addressing the issues uncovered through CLM with advocacy proposing practical, people-centered solutions and strong community involvement to support service delivery will enhance efficiency and ensure service continuity. This will pave the way for equitable and sustainable access to life-saving diagnostic and laboratory services.

There is a need to continuously monitor HIV diagnostic services, particularly now with the worldwide shifts in the HIV funding landscape, which are already having detrimental effects on national, regional, and international responses, while using community-generated data to inform programming and policy. The trends observed across the three countries likely represent only the early effects of the 2025 US funding cuts. Assessing the long-term impacts of funding cuts requires continued monitoring. Understanding how communities are meaningfully involved in mitigating these impacts and in the process of improving diagnostic systems is vital to ensuring that resilient and sustainable health systems are being built.

ANNEXES

ANNEX 1 – LIST OF INDICATORS

HIV SELF-TESTING	
Quantitative	**Qualitative [Respondent = HCW]**
1.1 # of HIV tests performed 1.2 # of HIV self-tests offered	· What type of HIV tests are proposed? · Where is HIV testing offered in the area where your health facility is found? · Do you offer HIV self-testing? · Do you perform confirmatory testing for people with a positive HIV self-test result?
EARLY INFANT DIAGNOSIS	
Quantitative	**Qualitative [Respondent = HCW]**
2.1 # of infants born to mothers living with HIV 2.2 # of infants born to mothers living with HIV receiving POC NAAT at 4-6 weeks from birth	· When is nucleic acid amplification testing (NAATs) performed on infants?
TB SCREENING	
Quantitative	**Qualitative [Respondent = Person living with HIV]**
3.1 # of people living with HIV who screened for TB	· How often does your healthcare provider ask you questions about having a cough, fever, weight loss, or night sweats during your health visits over the last year?
CD4 TESTING	
Quantitative	**Qualitative [Respondent = Person living with HIV]**
4.1 TOTAL # OF PEOPLE ELIGIBLE FOR CD4 CELL COUNTS 4.1.1 # of people eligible for a CD4 cell count at time of HIV diagnosis 4.1.2 # of people eligible for a CD4 cell count when re-entering HIV care 4.1.3 # of people eligible for a CD4 cell count as part of adherence counseling for unsuppressed VL 4.2 TOTAL # OF PEOPLE WHO RECEIVED A CD4 CELL COUNT 4.2.1 # of people who received a CD4 count at time of HIV diagnosis	· Do you know what a CD4 cell count is? · Why or when did you have a CD4 cell count? · If your most recent CD4 count was after January 2025, did you observe any changes in this service compared to preceding years? · Did anyone at the facility explain why you were getting a CD4 cell count? · How long did it take to get your result? · Did collecting your CD4 test results require a separate visit to the health facility, apart from your regular appointment? · Did anyone explain what your result meant? · What barriers or challenges to accessing this test did you encounter? · Were there any direct or indirect costs associated with the CD4 count test? (explain costs incurred) · What additional care did you receive? · Overall, are you satisfied with the additional care you received after the CD4 count test?
	Qualitative [Respondent = HCW]

4.2.2 # of people who received a CD4 count when re-entering care 4.2.3 # of people who received a CD4 count as part of adherence counseling for unsuppressed VL 4.3 TOTAL # OF PEOPLE WHO RECEIVED THEIR CD4 COUNT TEST RESULTS 4.3.1 # of people who received their CD4 count test results at time of HIV diagnosis" 4.3.2 # of people who received their CD4 count test results when re-entering HIV care 4.3.3 # of people who received their CD4 count test results as part of adherence counseling for unsuppressed VL" 4.4.1 "TOTAL # OF PEOPLE WHO HAD CD4 CELL COUNT BELOW 200 CELLS/MM^3" 4.4.2 "TOTAL # OF PEOPLE WHO WERE GIVEN SPECIAL CARE AFTER CD4 TEST (CD4 cell count was <200 cells/mm^3)"	· When is CD4 cell count performed for people living with HIV? · Do you offer point-of-care/rapid CD4 count? · Do you explain why the test is being done to people living with HIV before the test is done? · Do you explain what the results of the CD4 cell count mean to each person living with HIV? · What is done if a person has a CD4 count below 200 cells/mm^3?
VIRAL LOAD MONITORING	
Quantitative	**Qualitative [Respondent = Person living with HIV]**

<table>
<tr><td rowspan="3">5.1 # of people living with HIV eligible for a VL test
5.2 # of people living with HIV who have received a VL test
5.3.1 # of people living with HIV who received their VL test result within two weeks of taking the test
5.3.2 # of people living with HIV who had a blood sample taken for VL test but results never made available
5.4 # of people living with HIV who had a detectable viral load
5.4.1 # of people living with HIV who received enhanced adherence counseling and repeat VL testing after 3 months
5.4.2 # of people living with HIV who changed ART after receiving a viral load result</td><td>· Do you know what a viral load test is?
· If your most recent viral load test was after January 2025, did you observe any changes in this service compared to preceding years?
· Did anyone at the facility explain why you were getting a viral load test?
· How long did it take to get your result?
· Did collecting your viral load test results require a separate visit to the health facility, apart from your regular appointment?
· Did anyone explain what your result meant?
· What barriers or challenges to accessing this test did you encounter?
· Were there any direct or indirect costs associated with the viral load test? (explain costs incurred)
· What additional care did you receive?
· Overall, are you satisfied with the additional care you received after the viral load test?</td></tr>
<tr><td>Qualitative [Respondent = HCW]</td></tr>
<tr><td>· When are viral load monitoring tests performed for people living with HIV?
· Do you offer point-of-care/rapid tests for viral load?
· Do you explain why the test is being done to people living with HIV before the test is done?
· Do you explain what the results of the viral load test mean to each person living with HIV?
· What is done if a person has a detectable viral load?</td></tr>
<tr><td colspan="2">CHALLENGES AND IMPACT OF US FUNDING CUTS</td></tr>
<tr><td colspan="2">Qualitative [Respondent = Testing staff]</td></tr>
<tr><td colspan="2">• What issues or challenges did you face while providing these testing services?
• How can this site improve these testing services?
• How has the US funding cuts that started on 20 January 2025 impacted your work in this health facility?
• Is there anything else you would like to share related to the provision of this test?</td></tr>
</table>

ANNEX 2 – LIST OF DATA SITES

BURKINA FASO					
No.	**District**	**Name of health facility**	**Number of data collectors**	**US-funded site?**	**Type of health facility**
1	Bogodogo	CHU Charles De Gaulle	3	Yes	Tertiary
2	Baskuy	CHU Yalgado Ouédraogo	3	Yes	Tertiary
3	Dafra	CMA	4	Yes	Primary
4	Do	CHU Sourou Sanou		No	Tertiary
5	Dédougou	CHR Dédougou	2	Yes	Secondary
6	Gaoua	CHR Gaoua	2	No	Secondary
7	Banfora	CHR Banfora	2	No	Secondary
8	Koudougou	CHR Koudougou	2	Yes	Secondary
9	Ouahigouya	CHUR Ouahigouya	2	Yes	Secondary
10	Tenkodogo	CHR Tenkodogo	2	No	Secondary
11	Kaya	CHR Kaya	2	Yes	Secondary
12	Fada	CHR Fada	2	No	Secondary

DEMOCRATIC REPUBLIC OF CONGO					
No.	**District**	**Name of health facility**	**Number of data collectors**	**US-funded site?**	**Type of health facility**
1	Binza Météo	Centre de santé ASODEKI	1	Yes	Primary
2	Kikimi	Centre de Santé Marechal	1	Yes	Primary
3	Lingwala	Centre de santé de Référence Vijana	1	Yes	Secondary
4	Kingasani	Centre de Santé Polyclinique Light	1	Yes	Primary
5	Binza Météo	Centre de santé Église du Christ au Congo Mapasa	1	Yes	Primary
6	Bumbu	Centre de santé Libondi	1	No	Primary
7	Barumbu	Centre Hospitalier Boyambi	1	No	Secondary
8	Kalamu I	Centre Convivial IST Matonge	1	No	Primary
9	Lemba	Centre de santé de Référence Lisanga	1	No	Secondary
10	N'sele	Centre de santé Dream	1	No	Primary

SIERRA LEONE					
No.	**District**	**Name of health facility**	**Number of data collectors**	**US-funded site?**	**Type of health facility**
1	Western Area Urban	Princess Christian Maternity Hospital	3	No	Tertiary
2		Rokupa Government Hospital	2	Yes	Secondary
3		Lumley Government Hospital	3	Yes	Secondary
4		Murray Town CHC	2	Yes	Primary
5		Kissy CHC	2	No	Primary
6	Western Area Rural	Lakka Government Hospital	2	Yes	Secondary
7		Hastings CHC	2	Yes	Primary
8	Kenema	Kenema Government Hospital	1	No	Secondary
9	Port Loko	Port Loko Government Hospital	1	Yes	Secondary
10	Bo	Bo Government Hospital	2	No	Secondary
11	Moyamba	Moyamba Government Hospital	2	No	Secondary
12	Bombali	Makeni Government Hospital	2	No	Secondary

ANNEX 3 – ADVOCACY PLAN TEMPLATE

Name of Country Partner	
Project title	CLM for Labs
Donor	ITPC
Project duration	April-September 2025
Document Type	Advocacy plan for the CLM for Labs 2025
Advocacy lead	NAME, EMAIL

						Method of sharing data				
District	Data collection site	Key CLM findings	Advocacy issue [list all the issues connected to the site]	Advocacy objective	Target decision-makers to share data with [list all of the planned individuals, groups to share data with]	Meeting [add date, time other info of planned mtg]	Email [add individual/s, org/s, listserv/s to share data]	Media [indicate type of media used to share data]	Status of data sharing	Status of issue (resolved, pending, no longer advocating on this issue) [once data is shared, indicate the status to keep track]

ANNEX 4 – DETAILS OF STOCKOUTS AND EQUIPMENT MALFUNCTIONS

SUMMARY OF AVERAGE STOCKOUTS PER THEME AND COUNTRY			
Theme	**Average duration of stockout**		
	Burkina Faso	**DRC**	**Sierra Leone**
HIV test kits	10-90 days	10-70 days for HIV test kits and over a year for HIV/syphilis test kits	30-60 days
EID reagents and DBS supplies	126 days (ranging from 68 to 365 days)	414 days (ranging from 15 days to 4 years)	41 days (ranging from 3 to 122 days)
CD4 cell count supplies	No reports of stockouts	67-515 days for Visitect test strips (point-of-care testing)	10-30 days and up to 6 months to one year for Visitect test strips
Viral load monitoring supplies	32 days (ranging from 15 to 65 days)	295 days (ranging from 90 to 540 days)	25 days (ranging from 14 to 60 days)

Table 6: Summary of average duration of stockouts for HIV-related diagnostics

STOCKOUTS FOR HIV TESTING	
In Sierra Leone, 80% of healthcare centers reported shortages of HIV testing kits (including SD Bioline, Determine, Unigold, HIV/Syphilis Duo kits, and self-tests). In the DRC, 60% of facilities faced similar shortages, while in Burkina Faso, 50% reported interruptions in supplies of Determine kits and self-tests. Notably, the DRC's national testing algorithm includes a third confirmatory test that could not be performed due to prolonged stockouts.	
Average duration of stockout	**Reasons for stockouts**
Burkina Faso: 10-90 days for HIV test kits	National-level shortages and delayed procurement
DRC:10-70 days for HIV test kits and over a year for HIV/Syphilis test kits	- Failure of national supply (Global Fund & PEPFAR) - Under-delivery of quantities ordered -No district-level redistribution
Sierra Leone: 30-60 days	No or delayed supply from central store causing under-supply to facilities
EQUIPMENT MALFUNCTIONS FOR HIV TESTING	
No reports of any equipment malfunctions related to HIV testing were reported.	

Table 7: Country stockouts related to HIV testing

STOCKOUTS FOR EID AND PEDIATRIC ARV	
In Burkina Faso, multiple sites faced extended shortages of Xpert HIV-1 Qual reagents and DBS materials, lasting up to a year due to delays in national procurement. In the DRC, EID and pediatric HIV care were severely constrained by chronic shortages of reagents and filter paper, with some stockouts persisting since 2021. In Sierra Leone, temporary but recurrent shortages of EID commodities and pediatric ARVs occurred due to gaps in national supply, interrupting testing and infant follow-up.	
Average duration of stockout	**Reasons for stockouts**
Burkina Faso: 126 days (ranging from 68 to 365 days)	Multiple sites experienced prolonged shortages of Xpert HIV-1 Qual reagents, DBS cards, and sample collection materials due to national procurement delays and incomplete DBS kits.
DRC: 414 days (ranging from 15 days to 4 years)	A stockout was reported in one health facility affecting pediatric ARVs used for prevention and treatment of infants born to women living with HIV. In addition, a shortage of filter paper has been reported since 2021, preventing EID sample collection due to lack of materials. All shortages were attributed to absence of medicines and supplies at the health zone central depot.
Sierra Leone: 41 days (ranging from 3 to 122 days)	Shortages were experienced for EID sample collection cards, DBS cards and cartridges, and NVP syrup for infants born to women living with HIV due to lack of national supply.
EQUIPMENT MALFUNCTIONS FOR EID	
Equipment malfunctions affecting early infant diagnosis were reported primarily in three facilities in Burkina Faso and in one facility in Sierra Leone. No EID-related machine breakdowns were documented in the DRC during the reporting period.	
Average duration of malfunction	**Reasons for malfunctions**
Burkina Faso: 92 days (ranging from 7 to 180 days)	- Lack of maintenance - Inverter failure - Minor technical defects affecting GeneXpert and COBAS platforms
Sierra Leone: 9 months (ranging from 6 to 12 months)	Mechanical issues

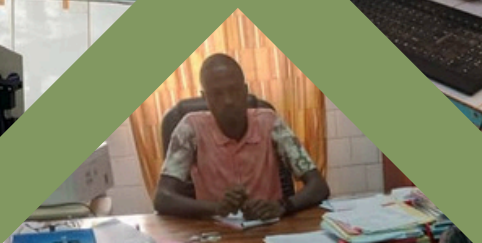
Table 8: EID and pediatric ARV stockouts and equipment malfunctions

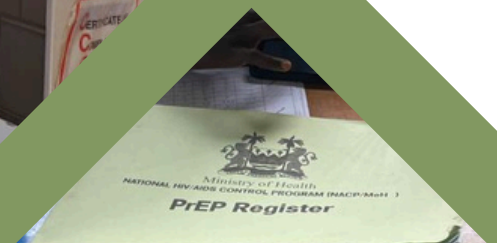
STOCKOUTS FOR CD4 CELL COUNT	
There were no stockouts reported in Burkina Faso, but this could be due to lack of information on the subject as CD4 is no longer a nationally monitored indicator. In the DRC, two out of the six health facilities offering CD4 testing were out of stock of the supplies (testing strip Visitect) to provide point-of-care CD4 testing. In Sierra Leone, one-third of health facilities were out of stock of the supplies for point-of-care CD4 testing.	
Average duration of stockout	**Reasons for stockouts**
DRC: 67-515 days for Visitect test strips	Failure of national supply
Sierra Leone: 10-30 days and up to 6 months to one year for Visitect test strips	No or delayed supply from central store causing under-supply to facilities
EQUIPMENT MALFUNCTIONS FOR CD4 CELL COUNT	
There were no equipment malfunctions reported in Burkina Faso, but this could be due to lack of information on the subject as CD4 is no longer a nationally monitored indicator. There were also no equipment malfunctions reported in the DRC. In Sierra Leone, one-quarter of health facilities reported equipment malfunctions for CD4 machines.	
Average duration of malfunction	**Reasons for malfunctions**
Sierra Leone: 30 days to one year	- Mechanical failure - Lack of maintenance - Electricity issues

Table 9: CD4 cell count-related stockouts and equipment malfunctions

STOCKOUTS FOR VIRAL LOAD MONITORING	
Stockouts of viral load-related supplies were reported in all three countries, disrupting the continuity and timeliness of testing. While most shortages were temporary, some lasted for over a year, highlighting persistent weaknesses in procurement planning and coordination between national, partner, and facility levels.	
Average duration of stockout	**Reasons for stockouts**
Burkina Faso: 32 days (ranging from 15 to 65 days)	Administrative delays, absence of supply from central level, and unfulfilled requisition requests
DRC: 295 days (ranging from 90 to 540 days)	Delayed or absent supply from central partners and sub-recipients
Sierra Leone: 25 days (ranging from 14 to 60 days)	- National stockouts - Transition from DBS to Plasma Separation Card sample collection cards in some facilities
EQUIPMENT MALFUNCTIONS FOR VIRAL LOAD MONITORING	
Malfunctions of viral load testing equipment were rare, but contributed to service interruptions where they occurred. In Burkina Faso, several health facilities reported periods of equipment downtime linked to maintenance gaps and technical issues; only one case was noted in Sierra Leone. No malfunction was reported in the DRC.	
Average duration of malfunction	**Reasons for malfunctions**
Burkina Faso: 95 days (ranging from 7 to 365 days)	- Lack of regular maintenance of machines - Technical failures, such as defective or missing memory cards - Infrastructure issues, including air conditioning breakdowns
Sierra Leone: No details provided	Only one facility reported a malfunctioning viral load machine during 2025, but no details were provided on the duration or reason for the failure.

Table 10: Viral load monitoring-related stockouts and equipment malfunctions





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