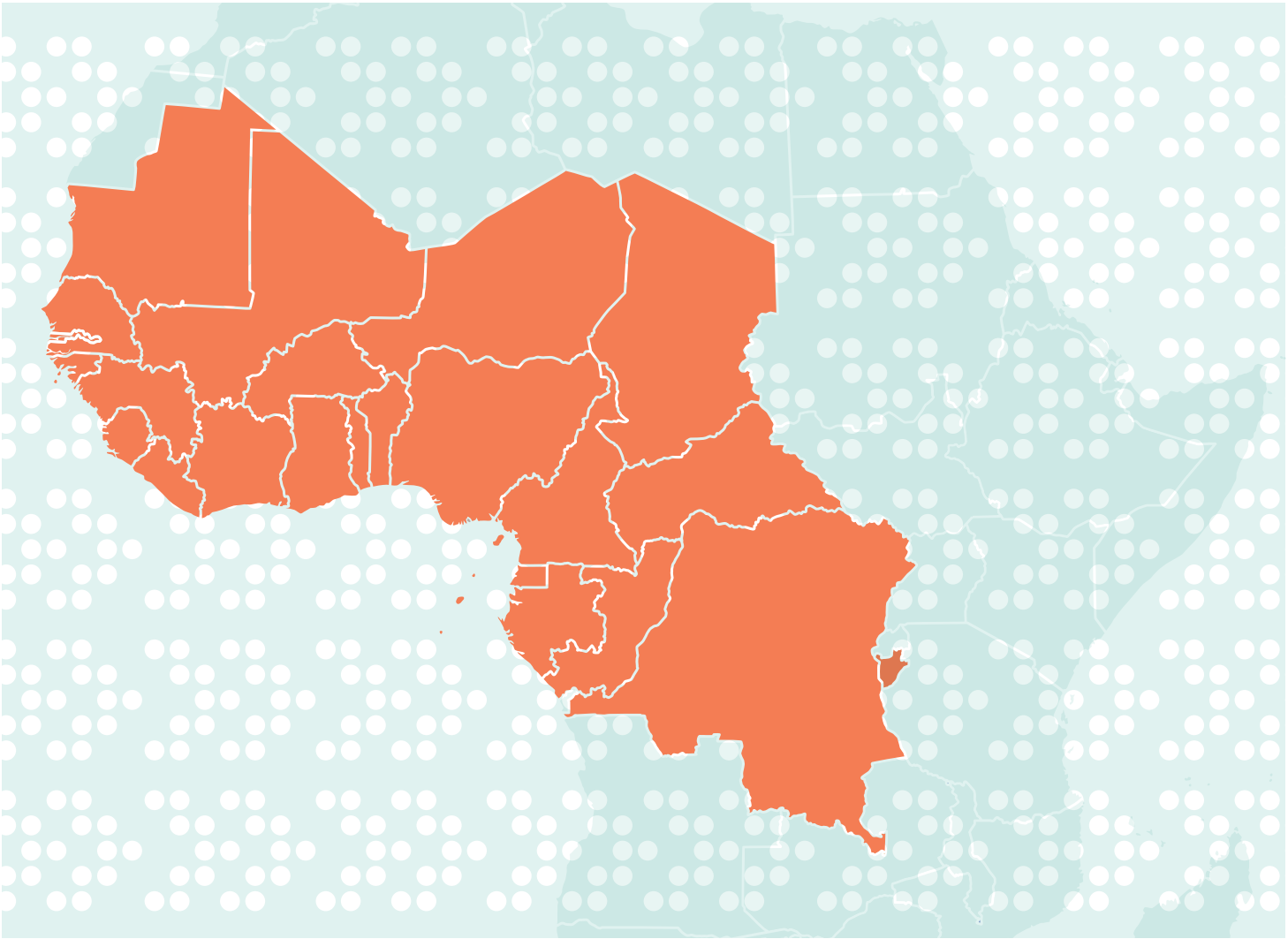
Action, innovation and solidarity

Building on momentum to close the gaps and leave no one behind in western and central Africa



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Introduction

HIV continues to have a profound humanitarian and public health impact in western and central Africa, a region that risks being left behind in the global response to ending the AIDS epidemic. Declines in the numbers of people acquiring HIV and dying from AIDS-related causes and increases in HIV treatment coverage in western and central Africa remain markedly lower than for low- and middle-income countries as a whole *(1)*. Indeed, the proportion of children living with HIV in western and central Africa who receive antiretroviral therapy, 26% [15–38%] is the lowest of any region in the world and half that of the global average.

Nevertheless, there is new hope in the response to AIDS in western and central Africa. In a major 2016 report that highlighted the lagging response to HIV in western and central Africa, Médecins Sans Frontières (MSF) identified key policy and programmatic issues requiring immediate action *(2)*. Later in 2016, UNAIDS Executive Director Michel Sidibé challenged countries in the region and the broader HIV community to triple the rate of initiation of antiretroviral therapy in western and central Africa over the next three years.

Countries in western and central Africa have heeded the call. National governments, civil society, international donors and multilateral agencies have joined together to commit to extraordinary action to close treatment gaps, improve the quality of care and put the region on track to end the AIDS epidemic as a public health threat by 2030. With the aim of avoiding a two-speed approach in the African quest to end the AIDS epidemic, the African Union in 2017 endorsed a regional catch-up plan for western and central Africa focusing on catalysing rapid progress towards the 90–90–90 targets. The regional catch-up plan aims by 2018 to:

- Reduce by 65% the number of people living with HIV who know their HIV status but are not receiving antiretroviral therapy.
- Increase by 45% the number of people newly tested for HIV.
- Increase by 50% the number of pregnant women receiving antiretroviral therapy.

In accordance with the regional targets, national catch-up plans have been put in place in 18 countries in western and central Africa. UNAIDS and partners, including the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), have given priority in assistance to eight first-wave countries in implementing the catch-up plan in 2017 (Cameroon, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Guinea, Liberia, Nigeria and Sierra Leone). In support of an accelerated response, several cities such as Yaoundé (Cameroon) and Kinshasa (Democratic Republic of the Congo) have signed on to the Fast-Track Cities Initiative, pledging to intensify local action to achieve the 90–90–90 targets.

This report provides an early snapshot of progress and challenges in western and central Africa in accelerating national HIV responses and an overview of prospects

for implementing national and regional catch-up plans. Since most of these national catch-up plans were put in place in the second half of 2017, it is arguably unreasonable to expect major changes in HIV epidemiological trends in the region by 31 December 2017, the data cut-off date for this report. Indeed, there is little evidence to date of declines in the number of people newly infected with HIV in the region in 2017 or the marked acceleration of service coverage.

However, there are signs that countries are planning, acting and innovating to address the well-documented challenges that the HIV response confronts in the region. Although regional evidence of a marked acceleration in the response is limited, several western and central African countries show important momentum in the response. Growing regional resolve to accelerate the response—combined with examples of where acceleration is occurring—provides hope that western and central Africa can sharply bend the trajectory of the HIV epidemic.

Despite these signs of hope, a fundamental question remains: will sufficient resources be available to translate this increasing commitment and growing know-how into concrete, accelerated progress? With international HIV assistance declining *(3)* and domestic outlays falling short of the amounts needed, there is a genuine risk that western and central Africa may permanently be left behind in the HIV response. This would be a historic error, since the relatively lower HIV prevalence in the region (compared with eastern and southern Africa) means that the region can, with action, lay the foundation to move towards the vision of zero new HIV infections, zero AIDS-related deaths and zero discrimination.

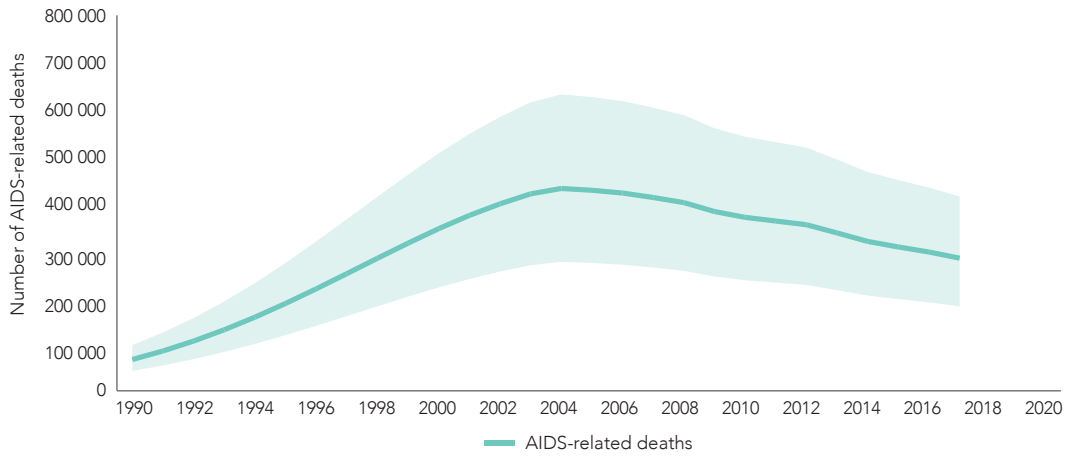
A status report on the response to HIV in western and central Africa

Since the world has focused on halting and reversing AIDS epidemics in countries in eastern and southern Africa with exceptionally high HIV prevalence, the response to HIV in western and central Africa has received substantially less attention and focus. Although HIV prevalence in western and central Africa among adults 15–49 years (1.9%; 1.4–2.6% in 2017) is indeed much lower than that in eastern and southern Africa (6.8%; 5.9–7.7%), HIV nevertheless constitutes a major public health problem in western and central Africa. In 2017, 6.1 million [4.4–8.1 million] people in the region were living with HIV, and an estimated 280 000 people [180 000–410 000] died from AIDS-related causes. Western and central Africa accounts for 7% of the world's population but for 17% of all people living with HIV and 21% of the people newly infected with HIV in 2017. Adult women (ages 15 years and older) comprise 59% of all adults living with HIV in western and central Africa. Although the regional HIV prevalence overall is lower in western and central Africa than in eastern and southern Africa, some countries in western and central Africa have very high HIV prevalence among adults 15 to 49 years of age, such as the Central African Republic, with an HIV prevalence of 4.0% [3.3–4.8%] in 2017.

The epidemic is exacting an especially heavy toll on children in western and central Africa. In 2017, an estimated 500 000 [320 000–690 000] children (0–14 years old) were living with HIV in the region, and an estimated 45 000 [24 000–69 000] children died from AIDS-related causes. Four in 10 children who die from AIDS-related causes globally are in western and central Africa.

The human impact of HIV in western and central Africa

Figure 1. Number of AIDS-related deaths, adults (aged 15 years and older), 1990–2017 and 2020 target



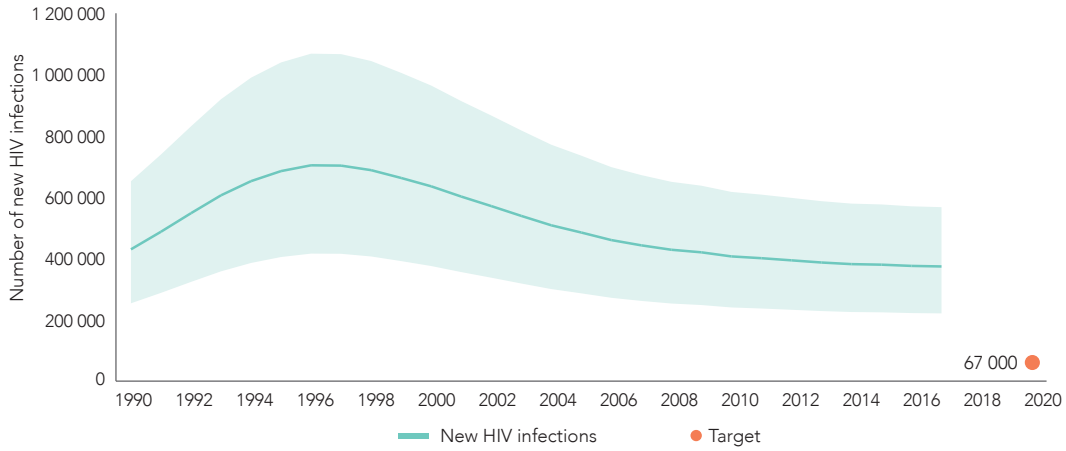
Sources: UNAIDS 2018 estimates.

Key trends in the HIV epidemic in western and central Africa are concerning. The number of people dying from AIDS-related causes 280 000 [180 000–410 000] has declined in the region—by nearly 24% from 2010 to 2017—but this reduction has been much more modest than the decline globally (34%) and is stagnating. The number of children dying from AIDS-related causes in western and central Africa fell by 29% from 2010 to 2017—more slowly than the decline globally (45%) or that in eastern and southern Africa (56%).

Western and central Africa had a statistically small decline (4%) in the number of adults acquiring HIV from 2010 to 2017, although this number fell globally by 16% and by 28% in eastern and southern Africa. The number of adults acquiring HIV in the region in 2017 [310 000;180 000–470 000] is more than four times greater than the 2020 Fast-Track target of no more than 67 000 new infections. In 2017, Nigeria alone accounted for 55% of the people acquiring HIV in western and central Africa and for about one in eight of the people acquiring HIV worldwide. Cameroon, Côte d'Ivoire and Nigeria together accounted for 71% of the people acquiring HIV in western and central Africa. The number of children acquiring HIV fell by 23% in western and central Africa from 2010 to 2017—notably less than the global decline (38%).

Moreover, the regional HIV response is leaving far too many groups behind, including young people. Since 2010, the number of adolescents (10–19 years old) dying from

Figure 2. Number of new HIV infections, adults (aged 15 years and older), 1990–2017 and 2020 target



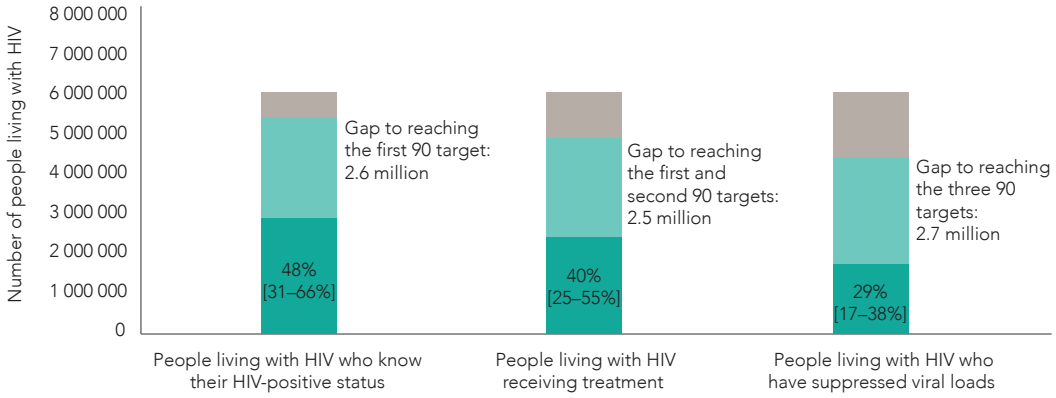
Sources: UNAIDS 2018 estimates.

AIDS-related illnesses in the region has increased by 4%, even as the numbers of people dying from AIDS-related illnesses overall have fallen among other groups.

Although HIV affects national populations across western and central Africa, the epidemic is exacting an especially heavy toll on certain populations. For example, although the national HIV prevalence among women ages 15–49 years in 2017 in Cameroon is less than 4%, an estimated 24% of female sex workers and 21% of men who have sex with men are living with HIV *(4)*. Nigeria has a similar pattern, with the HIV prevalence among adults being an estimated 3% nationally, but 22% of men who have sex with men and 14% of sex workers are living with HIV *(5)*. Altogether, key populations (including gay men and other men who have sex with men, people who inject drugs, sex workers and transgender people) comprise 24% of the people acquiring HIV in western and central Africa in 2017, even though they account for only a small fraction of the overall population.

Outcomes across the HIV treatment cascade

Figure 3. HIV testing and treatment cascade, western and central Africa, 2017



Sources: UNAIDS 2018 estimates; Global Aids Monitoring, 2018.

Although there is new political commitment in the response to HIV in the region, western and central Africa continues to experience major gaps at each stage of the HIV treatment cascade, lagging behind the rest of the world in HIV outcomes.

The first 90–90–90 target: knowledge of HIV status among people living with HIV

Knowledge of HIV status among people living with HIV is steadily increasing over time, but the pace of increase is insufficient to reach the 90% target by 2020. In 2017, 48% [31–66%] of the people living with HIV in western and central Africa knew their HIV status versus 38% [24–59%] in 2016 and 43% [27–59%] in 2015.

Men (38% of men living with HIV knew their HIV status in 2016) are markedly less likely than women (58%) to know their HIV status. This largely stems from gender differences in testing; in 2014, women comprised 70% of the people receiving HIV tests in western and central Africa. According to WHO, in Chad, Democratic Republic of the Congo, Gambia, Ghana, Liberia, Nigeria, Senegal and Sierra Leone, more than 70% of men have never been tested for HIV.

Although many fewer people living with HIV know their HIV status in western and central Africa than globally (where knowledge status is 75% [55–92%]), several countries have made important strides towards the first 90% target. In 2017, more than 70% of people living with HIV knew their HIV status in at least five countries (Burundi, Burkina Faso, Cameroon, Gabon and Senegal). Among countries in the region for which estimates are available for 2017,

fewer than 2 in 5 people were estimated to know their status in Congo, Mauritania and Nigeria.

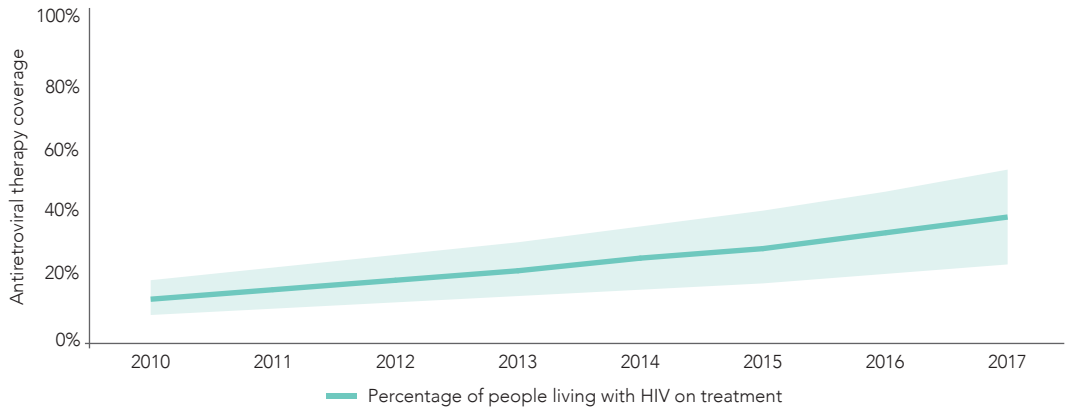
WHO's recommended "treat-all" approach calls for initiating HIV treatment as early as possible. As of mid-2017, WHO reported that only about one third of the countries in western and central Africa had begun to widely implement the "treat-all" approach. Because of inadequate uptake of HIV testing services, far too many people living with HIV in western and central Africa initiate antiretroviral therapy at a very late stage of HIV infection. Among nine countries in the region, most people starting HIV treatment in 2015 had a CD4 count of less than 200 cells/mm^3, when individuals are most vulnerable to HIV-related opportunistic infections, including tuberculosis (TB) and cryptococcal meningitis, and death *(6)*. In four countries in the region—Benin, Mali, Senegal and Togo—at least 70% of people initiating HIV treatment in 2015 had late-stage HIV disease *(6)*.

The second 90–90–90 target: antiretroviral therapy

In 2017, 40% [25–55%] of adults living with HIV in western and central Africa (83% [53–>95%] of all people with an HIV diagnosis) were receiving antiretroviral therapy, versus 35% [22–48%] in 2016. The 2017 coverage is roughly half the 81% targeted for 2020 in the 90–90–90 targets. HIV treatment coverage remains substantially lower in western and central Africa than global coverage (59% [44–73%] in 2017).

No evidence indicates that the pace of scaling up antiretroviral therapy accelerated in western and central Africa as a whole in 2017. In 2017, 15% more people received

Figure 4. Antiretroviral therapy coverage, western and central Africa, 2010–2017



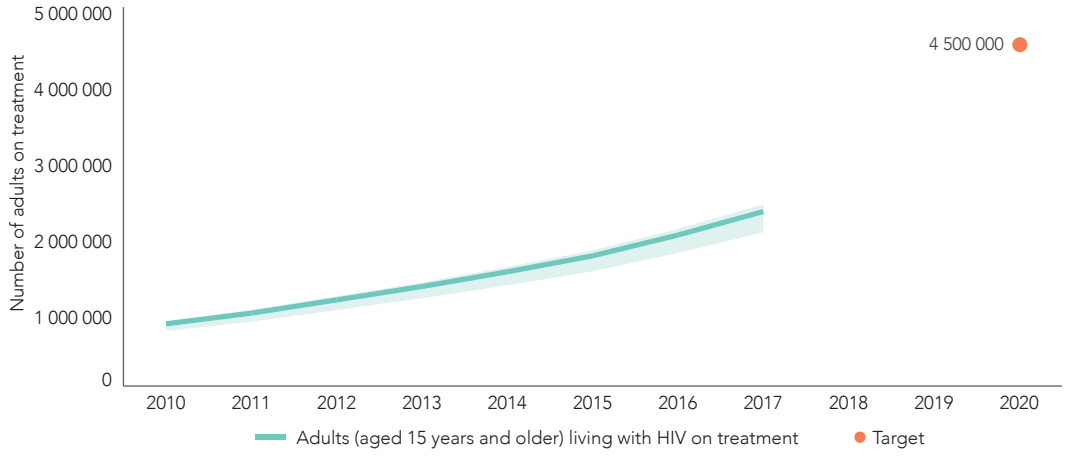
Sources: UNAIDS 2018 estimates; Global Aids monitoring, 2018.

treatment in western and central Africa than in 2016 while in 2016 the rate increase was 16%. Rates of increase are largely steady between 2011 and 2016. The pace of increase in treatment leaves western and central Africa well off that which is needed to reach Fast Track targets and end the AIDS epidemic in the region by 2030.

Several countries in the region have expedited the pace of initiating HIV treatment. For example, the number of adults receiving antiretroviral therapy in Cameroon rose by 24% from 2016 to 2017. In the Democratic Republic of the Congo, the rise from 2016 to 2017 in the number of adults accessing antiretroviral therapy was even sharper: 38%. In Congo and Sierra Leone, the increases in the number of people receiving HIV treatment in 2017 were 42% and 33%, respectively.

For the coming years, projected funding trends suggest that HIV treatment coverage will further increase in several countries in the region, although not at a pace that puts the region on track to achieve the second 90–90–90 target. In the countries of the region it funds for HIV services (not including Nigeria)[1], the Global Fund to Fight AIDS, Tuberculosis and Malaria projects that the number of people receiving antiretroviral therapy supported by the Global Fund and other sources will rise from 1.1 million in 2016

Figure 5. Number of adults (aged 15 years and older) receiving antiretroviral therapy in western and central Africa, 2010–2017 and 2020 target



Sources: UNAIDS 2018 estimates; Global Aids monitoring, 2018.

[1] The Global Fund analysis includes data from: Benin, Burkina Faso, Burundi, Cabo Verde, Cameroon, Chad, Central African Republic, Congo, Gambia, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Sao Tome and Principe, Senegal, Sierra Leone and Togo.

to 1.8 million in 2020 *(7)*. Although this projected increase is encouraging, it is far short of the tripling of the rate of treatment initiation called for in the catch-up plans. Even with new Global Fund grants, many countries face a considerable shortfall in funding to implement their plans for accelerating national responses. Indeed, the pace for scale-up the Global Fund projects for these countries is actually somewhat slower than the year-on-year increases reported for 2011–2017.

The United States President's Emergency Plan for AIDS Relief (PEPFAR) will also support the additional scaling up of treatment in the region. In three provinces of the Democratic Republic of the Congo, PEPFAR funding is anticipated to increase the number of people receiving antiretroviral therapy by September 2019 from 153 648 to 191 700, reaching 80% treatment coverage in these provinces *(8)*. In Cameroon, PEPFAR funding in 2018–2019 will initiate antiretroviral therapy for an additional 64 865 people, with national HIV treatment coverage expected to reach 76% by the end of 2019 *(4)*. With PEPFAR funding, the number of people receiving treatment in PEPFAR-supported areas of Nigeria is projected to rise from 772 510 in mid-2017 to 966 027 by September 2020 *(5)*.

The third 90–90–90 target: suppressed viral loads

Only 29% [19–40%] of people living with HIV were estimated to have suppressed viral loads in the region in 2017 versus 26% [16–36%] in 2016. An estimated 73% [47–>95%] of people receiving antiretroviral therapy in the region achieved suppressed viral loads in 2017—markedly lower than in eastern and southern Africa (79% [62–>93%]) and globally (81% [60–>95%]).

WHO reports that most countries in the region have formally adopted WHO's recommendation that viral load monitoring be routinely available to people receiving antiretroviral therapy. However, access to viral load monitoring remains extremely low in western and central Africa. In some countries in the region, less than 5% of people receiving treatment had access to viral load monitoring.

Among people receiving antiretroviral therapy, an estimated 79% [62–>93%] had suppressed viral loads—short of but potentially within reach of the third 90–90–90 target. Among countries in the region for which data on viral suppression were available for 2017, the rates were remarkably consistent, demonstrating that most people living with HIV on treatment suppress the virus.

However, treatment failure from the development of HIV drug resistance is increasing in western and central Africa *(9)*. Discontinuing antiretroviral therapy or otherwise failing to adhere to prescribed treatment regimens is a major cause of HIV treatment failure. Among 10 countries in western and central Africa reporting data in 2017 on retention in HIV care 12 months after initiating treatment among all ages, all but one (Côte d'Ivoire) reported retention rates lower than 80%. Several countries reported especially

concerning rates of retention in care, including Burkina Faso (62%), Gabon (57%) and Niger (27%).

Key populations often experience especially low rates of viral suppression, largely because of barriers to accessing timely HIV testing and treatment services. In Cameroon, for example, only 28% of HIV-positive men who have sex with men were receiving antiretroviral therapy, but none were retained in care after 12 months and none had documentation of viral suppression.

Inadequate viral suppression accelerates disease progression and facilitates the transmission of drug-resistant HIV. In Cameroon, 8% of the people initiating antiretroviral therapy in 2014–2016 had pretreatment resistance to non-nucleoside reverse-transcriptase inhibitors *(10)*.

HIV, pregnant women and children

Countries in western and central Africa played an important role in developing and launching the multi-partner Start Free Stay Free AIDS Free initiative, which calls for super-Fast-Tracking HIV responses for pregnant women, children and families, with the goal of ending the AIDS epidemic among children, adolescents and young women by 2020. The initiative calls for reaching and sustaining lifelong antiretroviral therapy for 95% of pregnant women by 2018 and for rapidly scaling up HIV treatment services for children. However, the results from 2017 indicate that western and central Africa is not on track to attain these super-Fast-Track targets.

Preventing children from acquiring HIV

The spectrum of interventions that together prevent children from becoming newly infected with HIV has yet to be applied at scale across the region. In 2017, 170 000 [99 000–250 000] women 15 years and older were newly infected with HIV in western and central Africa—only a 5% reduction compared with 2010. The continuing high rate of women of reproductive age acquiring HIV increases the risks of mother-to-child transmission.

Women in western and central Africa also continue to lack access to essential tools for family planning and birth spacing. In 2017, contraceptive use was lower in Africa than in any other region, and within Africa, the lowest rate of contraceptive use was in western Africa (20%) *(11)*.

Western and central Africa is also far from achieving 95% coverage of antiretroviral therapy among pregnant women by 2018. Coverage of effective antiretroviral therapy regimens among pregnant women in 2017 was only 48% [32–65%] in western and central Africa versus 80% [61–>95%] globally. Even more concerning, antiretroviral therapy coverage in 2017 among pregnant women in the region actually declined from 2016, when 50% [34–68%] of pregnant women received treatment.

However, regional figures obscure important gains made in some countries in western and central Africa. According to data reported to UNAIDS, treatment coverage among pregnant women in 2017 exceeded 80% in six countries in the region (Benin, Burkina Faso, Burundi, Cabo Verde, Liberia and Sierra Leone). Coverage exceeded 60% in 13 of 24 of countries in the region. The discouraging regional average largely stems from the very low coverage (30% [19–44%]) reported for Nigeria, the most populous country in the region.

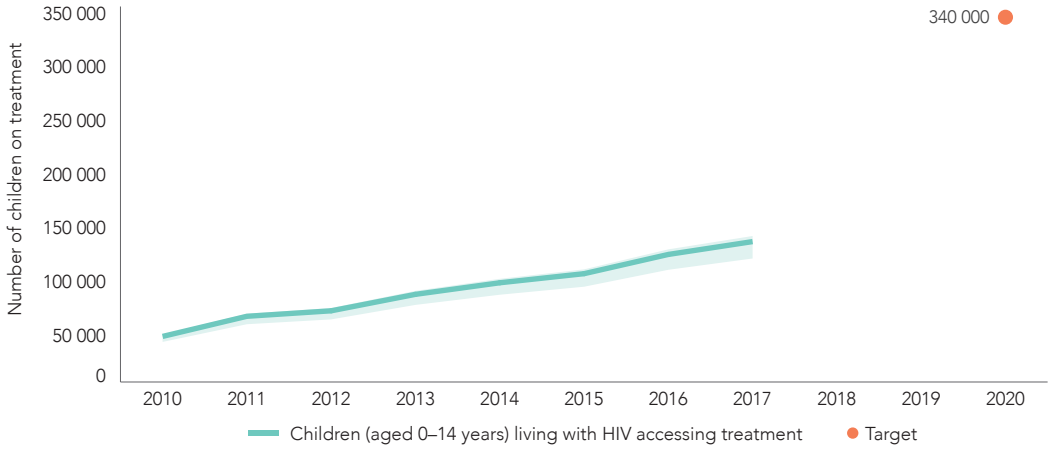
HIV treatment for children

The estimated 500 000 [320 000–690 000] children living with HIV confront extremely limited access to antiretroviral therapy and often too late, contributing to children's disproportionate AIDS-related morbidity and mortality. Although HIV treatment coverage among children in western and central Africa roughly tripled from 2010 to 2017, the increase began from a very low level. Regional treatment coverage among children remains extremely low—26% [15–38%] in 2017. Low treatment coverage of children prevails across the region, with the highest coverage in 2017 reported in Cabo Verde (92%; [64–>95%]) and Gabon (50%; [36–60%]). Current trends put the region badly off the pace for implementing the Fast-Track approach for children.

A failure to ensure prompt diagnosis of children contributes to both very low treatment coverage and disproportionately high number of children dying from AIDS-related causes in the region, since children with perinatally acquired HIV face 50% odds of dying before age two years without antiretroviral therapy. In 2016, only 20% of HIV-exposed children received early infant diagnostic services within the first two months of life *(12)*.

In part, low diagnostic coverage of children stems from the very low number of early infant diagnostic laboratories in the region and the concentration of testing platforms in major cities, which in turn contributes to challenges in transporting blood specimens

Figure 6. Number of children (aged 0–14 years) living with HIV accessing treatment, western and central Africa, 2010–2017 and 2020 target



Sources: UNAIDS 2018 estimates; Global Aids monitoring, 2018.

and promptly returning test results *(12)*. The average lag between sample collection and receiving early infant diagnosis test results was 1.4 months in Nigeria, 1.7 months in Cameroon, 2.2 months in Togo, 2.3 months in the Democratic Republic of the Congo and 3.5 months in Ghana *(13)*.

Although data on retention in HIV care among children is limited for western and central Africa, available evidence indicates that many children in the region who initiate antiretroviral therapy fall out of care and are lost to follow-up. Among eight countries in the region reporting data to UNAIDS for 2017, more than 30% of children who initiated antiretroviral therapy were no longer in care 12 months later in four countries: Equatorial Guinea, Gabon, Mauritania and Niger.

HIV testing and treatment services for children urgently need to be radically scaled up. Noting that the aspects of national catch-up plans related to children are often weak, stakeholders attending a meeting convened by UNICEF and UNAIDS, in collaboration with others, at the 2017 International Conference on AIDS and STIs in Africa urged that countries revise these plans to specifically give priority to HIV treatment for children and to align national targets with the super-Fast-Track approach *(13)*. To implement the recommended approach, UNICEF, UNAIDS and WHO supported Mali in developing strategies and set targets for children to take into account in the national catch-up plan. Similar efforts are expected to be completed in five additional countries in the region by the end of 2018. To translate HIV commitments for children into action, high-level political and community leaders need to be engaged, innovative technologies (such as point-of-care early infant diagnosis) need to be brought to scale and differentiated service delivery strategies (including family testing and longer prescriptions for antiretroviral medicines) and task-shifting approaches should be applied to HIV care and treatment services for children.

Addressing priority action areas to unblock progress

Although new political momentum in the regional AIDS response is encouraging, translating these commitments into concrete results requires smart, sustained action to overcome key impediments to a robust HIV response in the region.

Exert robust leadership to Fast-Track the response

The endorsement by African leaders of the catch-up plans for the region as a whole and the launch of national catch-up plans in 18 countries in western and central Africa clearly demonstrate growing commitment to the HIV response in the region. These catch-up plans elevate regional and national aspirations and clearly define key milestones towards ending the AIDS epidemic in the region.

The regional and national catch-up plans have attracted substantial technical support to accelerate AIDS responses in western and central Africa. Regional workshops have been undertaken to share best practices and catalyse progress in implementing differentiated models of service delivery for HIV testing and treatment. In the 12-month period ending on 31 March 2018, UNAIDS undertook 87 technical support projects in 18 countries in the region with the aim of building national capacity to Fast-Track national responses. PEPFAR also provides extensive technical support for national responses, including support for strengthening national systems for collecting and using strategic data, improving the targeting of HIV testing efforts, enhancing linkage to care and retention in care and strengthening laboratory capacity (personal communication, Julia Martin, PEPFAR, 5 June 2018).

The Democratic Republic of the Congo illustrates the kind of multi-partner leadership needed for the regional catch-up plan. In response to the call of UNAIDS Executive Director Michel Sidibé for countries in western and central Africa to radically accelerate their national HIV responses, the country's Ministry of Health and the national AIDS commission convened a participatory process to develop a national HIV catch-up plan. The catch-up plan targeted the three most severely affected provinces—Katanga, Kinshasa and Orientale—with the aim of providing antiretroviral therapy to at least 80 000 newly diagnosed people by June 2018. The catch-up plan gave priority to full implementation of the "treat-all" approach, task shifting, differentiated service delivery models, community-based delivery of services for preventing mother-to-child transmission, using mother-mentors to scale up early infant diagnosis and implementing one-stop-shopping models for integrating HIV and TB services. To support the national catch-up plan, civil society networks developed an operational plan for scaling up community antiretroviral medicine distribution, and implementation of the catch-up plan was actively supported by external partners, including through a joint mission of UNAIDS, WHO, UNICEF, MSF, the Global Fund, PEPFAR and nongovernmental and civil society organizations. Leadership, active involvement and the collaboration of diverse stakeholders

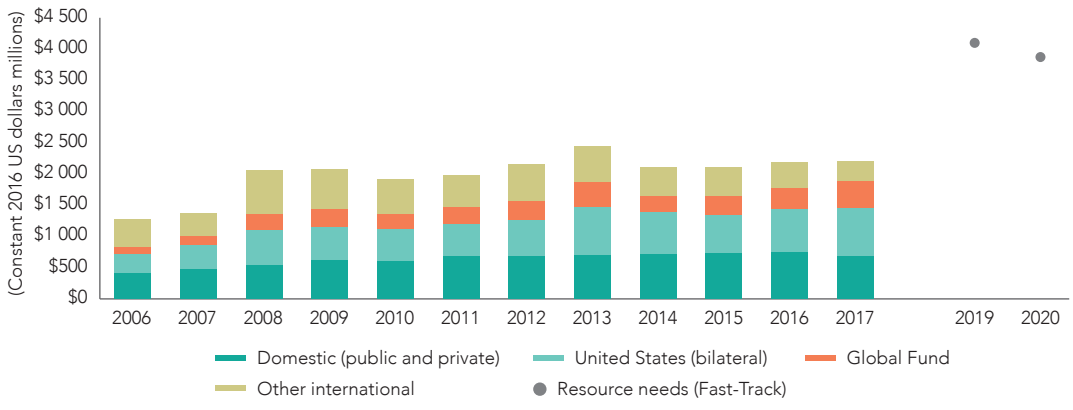
achieved results, with the country exceeding its target to diagnose and initiate antiretroviral therapy for at least 80 000 newly diagnosed people by the agreed deadline.

Mobilize additional funding and sustainable financing

Among the most perilous threats to new momentum in the HIV response in western and central Africa is a looming gap in essential financing. A shortfall in resources could undermine the encouraging adoption of policy changes, effective and innovative strategies seen in many countries. As the region embarks on an urgent effort to vastly increase access to HIV treatment services, sufficient financing is vital for procuring commodities, human resources for health, strengthening health and community systems and other key activities.

Pledges to accelerate the HIV response in the region have not been accompanied by a surge in resource mobilization as of December 2017. The total resources available for HIV programmes in western and central Africa peaked in 2013, at US$2.44 billion. In subsequent years, total financing for the response has stagnated, fluctuating between US$2.1 billion and US$2.2 billion annually. In 2017, US$2.1 billion was available for HIV programmes in the region. In 2017, the total resources needed to implement the Fast-Track approach are 81% greater than the amounts available in 2017.

Figure 7. HIV resource availability 2006–17 and 2019–2020 Resource Needs in WCA (Constant 2016 US dollars millions)



Sources: UNAIDS resource availability and needs estimates, 2018.

UNAIDS' latest estimates are that domestic resources accounted for 31% of available resources for the HIV response in western and central Africa in 2017. Since 2013, UNAIDS monitoring indicates that total domestic resources for HIV in the region have remained flat, with no sign that political commitments to strengthen the HIV response have been matched by increased allocation of resources.

Domestic underinvestment in the HIV response is merely one component of a broader underinvestment in health across western and central Africa. Although all African countries committed in the 2001 Abuja Declaration to allocate at least 15% of their government budget to health, only one country in the region (Gambia, 15.3%) has met this target *(16)*. Most countries in the region (including Benin, Cameroon, Chad, Congo, Côte d'Ivoire, Equatorial Guinea, Ghana, Guinea, Guinea-Bissau, Mali, Mauritania, Niger, Nigeria, Senegal and Togo) spend less than 10% of the government budget on health *(14)*. Even when governments give priority to health, the domestic resources mobilized are often insufficient to reach the recommended levels of investment. In 2015, only four countries in the region (Cabo Verde, Congo, Equatorial Guinea and Gabon) invested domestic resources for health equivalent to US$86 per capita per year, the target recommended by the high-level Taskforce on Innovative International Financing for Health Systems *(15)*. According to projections through 2040, barring major changes in resource mobilization and political priority-setting, total health spending in western and central Africa will remain low over the next two decades, in part because of the limited fiscal space in many countries *(16)*. Health systems are often especially weak and underresourced in the numerous countries in western and central Africa that have experienced persistent instability, crisis and recurrent violence.

Although domestic allocations for health and for HIV specifically must clearly increase, western and central African countries confront considerable challenges, since donors increasingly aim to transition national programmes to domestic support. Many countries in the region have limited fiscal space. International assistance continues to be highly variable from year to year, and numerous donors have pursued transition efforts in a wide array of health areas, posing considerable financing and administrative challenges for countries in the region. These many challenges underscore the need for robust, sustained international support to enable the region to get on track to reduce the number of people acquiring HIV and dying from AIDS-related causes.

PEPFAR allocations and expenditure vary year by year in the six countries in which it has programmes (Burundi, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Nigeria and Ghana) *(17)*, and total PEPFAR financing for the region has fluctuated between US$612 million (2015) and US$766 million (2013). In 2017, PEPFAR provided US$755 million in HIV assistance to countries in western and central Africa—approaching its peak year of support in 2013.

Global Fund disbursements for HIV programmes in the region has fluctuated year by year, although it peaked in 2017, at US$433 million, increasing by 28% compared with 2016. Global Fund allocations in the region in 2018–2020 (projected at US$1.024 billion) are expected to remain roughly equivalent to the amounts disbursed in 2015–2017 (US$1.039 billion) *(7)*. Citing limited absorptive capacity, as reflected by a 68% disbursement rate for Global Fund grants in 2016, the Global Fund's HIV allocations for 2018–2020 are about one third lower than the annual signed grant amounts under its new funding model *(7)*. According to surveys of country stakeholders undertaken by the Africa Constituencies Bureau, low absorption of Global Fund grants in western and central Africa stem from numerous factors, and this suboptimal absorption indicates the need for additional focused support to address health system weaknesses rather than cuts to essential funding *(18)*. Recent reports indicate that absorption problems in the region have substantially eased and that the amount of unspent funds has declined.

Other countries are also helping countries in western and central Africa in their catch-up efforts. Luxembourg has contributed US$1 million a year to assist in accelerating progress towards the 90–90–90 targets in western and central Africa. France withholds 7% of its annual contribution to the Global Fund, earmarking this funding for technical support for Global Fund grant recipients, with a specific although not exclusive emphasis on francophone countries. In support of the acceleration efforts in western and central Africa, France Expertise Internationale provided technical and financial support for rolling out civil society–led observatories.

The confluence of these trends—insufficient domestic financing and declining international HIV assistance—poses a potentially existential challenge to regional hopes for catching up in the HIV response. In particular, a rapid shift of responsibility to national governments for financing national HIV programmes can outstrip the capacity of countries. For example, the Government of Guinea, under its new HIV grant with the Global Fund, is expected to assume responsibility for financing two thirds of the new people initiating antiretroviral therapy within two years, although the Global Fund's Technical Review Panel determined that national targets are already "too low to have a meaningful impact on the epidemic" *(19)*. Without additional resources—from domestic budgets, innovative financing, sustainable borrowing or increased international assistance—it is unclear how Guinea will have the means to scale up antiretroviral therapy. Similarly, while Global Fund assistance has enabled important progress in increasing HIV treatment coverage in the Central African Republic—from 12% in 2010 to 33% in 2017—the country's new grant with the Global Fund does not include funding for new treatment initiation in 2019 or 2020.

A combination of approaches to achieve greater funding from diverse actors will be needed to close the looming resource gap in western and central Africa. This is a matter of urgent importance, since investments need to be front-loaded to

enable responses in the region to catch up to the Fast-Track approach. Social health insurance schemes and other steps towards universal health coverage offer a potential longer-term avenue for mobilizing resources for HIV services, although progress in implementing these approaches has been slow in western and central Africa *(20)*. For example, Gabon increased viral load testing coverage from 2% in 2016 to 11% in 2017 by including viral load monitoring in the health insurance packages available to low-income earners.

End stigma and discrimination

Civil society representatives cite violations of human rights and gender inequality as key obstacles to effectively implementing catch-up plans *(21)*. International donors also indicate that persistent stigma is a central obstacle to an effective AIDS response in the region (personal communication, Julia Martin, PEPFAR, 5 June 2018). Individuals who fear that they will not receive high-quality, non-discriminatory treatment in health services or that they may lose a job or family ties if they test HIV-positive frequently avoid seeking HIV services. Some who learn their HIV status and initiate antiretroviral therapy may discontinue care in response to providers' stigmatizing attitudes or social prejudice they have experienced.

In recent surveys, at least 40% and up to 80% of adults in western and central African countries said they would not buy vegetables from a person living with HIV. Surveys using the People Living with HIV Stigma Index document the extent and negative ramifications of stigma. In the Democratic Republic of the Congo, more than three in four people surveyed said that individual HIV status is the root cause of stigma and discrimination, with more than half of the 33% of the respondents who lost a job in previous 12 months citing their HIV status as the reason for their dismissal *(22)*. Surveys of people living with HIV in Senegal reported similar results, with 38% experiencing an episode of stigma or discrimination in the previous year *(23)*; in Nigeria, with one in five respondents reporting having been denied access to health services in the past year because of their HIV status; and in Cameroon, with more than two thirds of the respondents experiencing some form of stigma or discrimination *(24)*.

Stigmatizing attitudes towards people living with HIV are often encouraged or institutionalized through discriminatory legal and policy frameworks. At least 16 countries in western and central Africa have laws that criminalize HIV non-disclosure, exposure or transmission, and prosecutions for such offences have occurred in at least six countries *(25)*. Scientific experts are increasingly calling for the immediate repeal of such statutes, not only on human rights grounds but also because such laws ignore the fact that people living with HIV cannot infect others if they receive antiretroviral therapy and achieve viral suppression *(26)*. Other laws and policies exacerbate HIV stigma by targeting populations at high risk of HIV infection; in 2017, for example,

at least 11 countries in western and central Africa had laws in place criminalizing same-sex relations or expression, and no country in the region recognized same-sex partnerships *(27)*. Mandatory pre-marital testing has been reported in countries such as Democratic Republic of the Congo, Ghana, and Nigeria. Advocacy and legal reviews can play a critical role in encouraging the repeal or revision of discriminatory laws; in 2017, for example, UNAIDS supported a review of the legal and policy framework in the Democratic Republic of the Congo with the goal of strengthening legal protections for people living with HIV. Law reform on criminalization of HIV nondisclosure, exposure and transmission is happening in a number of countries. Countries such as the Democratic Republic of the Congo , Guinea, Senegal, and Togo have reformed their legislation to restrict the use of criminal law to cases of intentional transmission. International observers reported that the legal situation for people living with HIV has improved in recent years in Sierra Leone *(25)*. In 2017, the Nigerian National Agency for the Control of AIDS clarified that national law in no way limits access to HIV services, and steps were also taken to educate and mobilize communities of key populations regarding their rights. Work is underway in Sierra Leone to remove the age threshold for a young person to receive health services without parental consent, and the country has also assessed its legal environment and received Global Fund support to remove legal barriers to accessing HIV services.

Training and sensitizing health-care workers to reduce prejudicial attitudes towards people living with HIV and members of key populations and reductions in avoidance intent (not wanting to care for patients living with HIV) are urgent priority for the regional HIV response. Some countries are training health-care workers and law enforcement agents on health and human rights, but these programmes have yet to be brought to scale, since only 25% of the countries in the region have implemented these approaches

A report, "The HIV, the law and Human Rights in the African Human Rights System: Key challenges and opportunities for Right based responses", developed by the African Commission on Human and Peoples' Rights, provides an updated and detailed analysis of key challenges and human rights violations. It also highlights best practices and other promising practices at the regional or national level to raise the awareness of States and other stakeholders on the need to integrate the human rights dimension as a key component in efforts to combat HIV.

Increase knowledge of HIV status

The countries in western and central Africa have long used provider-initiated testing and counselling as the primary strategy for delivering HIV testing services. Accelerating progress towards the first 90–90–90 target requires expanding the region's approach to HIV testing beyond its traditional reliance on health facilities. Bringing testing services closer to communities, making testing more convenient and tailoring services to the

needs of users can enable western and central Africa to substantially increase the proportion of people who know their HIV status. Nesting HIV testing within multi-disease campaigns yields broad-based health benefits, helps overcome the stigma associated with HIV testing and enhances synergy between HIV and TB, viral hepatitis, cervical cancer and hypertension programmes *(28)*.

Countries in the region are already leveraging technical support from UNAIDS, PEPFAR and other partners to expand the range of testing options and to better target testing services, including through a regional workshop on differentiated approaches to HIV testing. Niger, for example, intends to support family testing, community testing (especially focusing on men), couples testing and assisted partner notification. In the Central African Republic, implementation of diverse testing approaches (including family testing, services for hospitalized and malnourished children and other approaches) reached nearly 10 000 children from 5759 families of people living with HIV, identifying more than 700 new cases of HIV infection. The Cameroon National Association for Family Welfare uses community-affirming, decentralized approaches to link men who have sex with men and transgender people for HIV testing. Other countries, including Benin, Burkina Faso, Cameroon, Chad, Guinea and Togo, are undertaking efforts to expand the range of testing options.

Various approaches to community-centred testing have proven highly effective in rapidly increasing the proportion of people who know their HIV status and in mitigating longstanding inequities in testing uptake, including suboptimal knowledge of HIV status among men and young people *(28)*. In the Democratic Republic of the Congo, community-based testing and referrals had identified 84 000 people with new HIV diagnoses by June 2018 and linked these individuals to antiretroviral therapy. A regional project by nongovernmental organization Enda Santé Sénégal promotes the access of key populations to health services at the border posts between Senegal, Gambia and Guinea-Bissau. In the Central African Republic, strong involvement by communities has facilitated the implementation of differentiated service delivery, re-engagement of individuals who have fallen out of HIV care and diversified testing approaches, including testing the spouses of pregnant and breastfeeding women living with HIV and testing in various community locations, such as churches, schools, markets, neighbourhoods and camps for displaced individuals.

Rapidly scaling up community-based testing approaches in western and central Africa requires that countries in the region formally permit and actively promote the shifting of clinical, testing and counselling tasks from higher-cadre to lower-cadre health and community workers. Some countries in the region, such as Ghana, have invested in recruiting, training and deploying community health workers, but community workers currently play only a relatively minor role in delivering HIV services in western and central

Africa *(2)*. This needs to change for the region to achieve the first 90–90–90 target and get on track to ending the AIDS epidemic.

According to WHO, as of mid-2017, most countries in western and central Africa had yet to formally implement HIV self-testing. Several countries in the region are actively exploring or making specific plans for introducing HIV self-testing, which allows individuals to screen for HIV in the privacy of their own homes.

Given the very low rates of prompt diagnosis among children living with HIV in the region, urgent action is needed to intensify and expand testing options for children. In particular, point-of-care early infant diagnosis technologies, which can deliver test results on the same day a specimen is collected, should be scaled up in decentralized service delivery settings. UNICEF and an array of global partners have prepared step-by-step guidance to aid countries in introducing HIV point-of-care early infant diagnosis technologies *(29)*. With aid from Unitaid, the Clinton Health Access Initiative and UNICEF, four countries in the region (Cameroon, Côte d'Ivoire, Democratic Republic of the Congo and Senegal) are introducing point-of-care early infant diagnosis *(12)*. In six countries in the region (Burkina Faso, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Senegal and Togo), the Clinton Health Access Initiative projects that the use of point-of-care early infant diagnosis will increase from less than 45 000 tests in 2017 to nearly 65 000 in 2022 (personal communication, Naoko Doi, Clinton Health Access Initiative, 8 July 2018)—an encouraging trend, but nevertheless still far short of the rapid scaling up warranted by the region's crisis of HIV treatment for children. In addition, since most HIV-exposed children in the region are still unlikely to be identified through services to prevent mother-to-child transmission, testing for children should be made readily available in a variety of health and community settings *(13)*.

UNICEF, UNAIDS and WHO are supporting a regional campaign to promote the roll-out of family-based testing and care. To address the challenging situation for HIV among children in the region, UNICEF and UNAIDS in collaboration with WHO are planning to launch a regional family-centred index case testing and care campaign to be integrated into countries' catch-up plans. The family testing (or index case testing) campaign will be anchored in the Free to Shine Africa campaign led by the Organization of African First Ladies against HIV/AIDS and the African Union, with the aim of increasing the early identification of children living with HIV and retaining children and their families in HIV care services.

Tailored testing approaches are needed for populations that are underserved by existing testing strategies. For example, to close the testing gap for men, innovative service delivery strategies may be needed, such as expanded service hours that accommodate workers or service sites specifically dedicated to men. Service platforms should be adapted to be adolescent-friendly, including incorporating peer interventions and using youth-centred communication strategies; WHO recommends that HIV testing services

be offered to adolescents from key populations in all settings *(30)*. Diverse community-centred models—such as outreach clinics, drop-in centres, stand-alone clinics specifically dedicated to key populations, and self-testing—will be required to increase knowledge of HIV status among key populations.

End-user fees for health services for people living with HIV

Although commodities for both HIV testing and antiretroviral therapy are supposedly provided free of charge to people living with HIV in western and central Africa, the reality is that using services is associated with substantial and often unaffordable costs. A three-country study of HIV-related medical costs by MSF found that people receiving an HIV test in certain health settings in Bangui had to pay US$1.80 out of pocket *(31)*. In Conakry, Guinea, the initial consultation for people living with HIV in some HIV service settings can cost as much as US$33.16 out of pocket, with additional costs associated with each subsequent consultation *(31)*. Although antiretroviral medicines may be available free of user charges in Conakry, people living with HIV must pay more than US$6 monthly in some settings for co-trimoxazole *(31)*. A CD4 test can cost US$20–40 out of pocket in Bangui, Central African Republic, and hospitalization for advanced HIV disease in Kinshasa, Democratic Republic of the Congo may cost up to US$280, or about five months' salary for the 77% of the population living on less than US$1.90 per day *(31)*.

These user fees are prohibitive, especially for the majority of the population that is living in poverty, and they deter people from using essential health services. In particular, requiring out-of-pocket payments is associated with lower rates of HIV treatment initiation and retention in care *(32,33)*. In Kinshasa, Democratic Republic of the Congo, people with advanced HIV disease cite the costs associated with medication and care as a primary reason why they delayed seeking health care or interrupted HIV treatment *(31)*. Although the Global Fund covers the costs associated with HIV diagnostic and treatment services in many countries, user fees routinely applied across the region effectively amount to making people pay again for the same services *(31)*. MSF reports that the use of primary care services in some countries, such as Ghana, Liberia, Niger and Senegal, has increased when user fees have been abolished.

The negative public health effects substantially outweigh the marginal funding user fees generate for health systems. Although they are designed to generate revenue, these fees may actually increase costs for health systems, since people who delay seeking HIV testing and treatment services are more likely to require intensive and costly hospitalization for late-stage care. Countries should urgently take steps to ensure that all aspects of HIV treatment (including laboratories, clinical consultations, treatments for both HIV infection and opportunistic infections and hospitalization) are provided completely free of user charges *(31)*. To support and inform efforts in the Democratic Republic of the Congo to remove financial barriers to HIV service uptake, UNAIDS

facilitated a comprehensive literature review of how user fees affect health service uptake and health outcomes in 2017–2018.

Implement differentiated service delivery

Historically, HIV care and treatment has been centralized and highly medicalized in health-care facilities. This approach expects people living with HIV to adapt themselves to existing systems rather than having services adapt to users' needs and preferences. A centralized, highly medicalized approach to treatment delivery also ignores the potential of decentralized, community-led approaches to reaching individuals not effectively served by mainstream health-care facilities. The 2016 Political Declaration on HIV and AIDS calls for community-led service delivery to account for at least 30% of HIV services by 2030.

To transition HIV treatment services beyond health-care facilities and bring services closer to the people who need them, many differentiated service delivery strategies have emerged *(34)*. These approaches draw on community resources and systems, recognize the wide diversity of service needs among people living with HIV and permit approaches to be tailored to each person's needs and circumstances. WHO recommends that people stable on antiretroviral therapy have reduced clinic visits and opportunities for community antiretroviral medicine distribution and receive three- to six-month supplies of antiretroviral medicines. Differentiated service delivery strategies have proven especially useful in maintaining HIV treatment services in settings affected by conflict or other crises *(35)*.

MSF has pioneered several differentiated service delivery approaches specifically designed to address service delivery challenges in western and central Africa. In Kinshasa, Democratic Republic of the Congo, MSF piloted community antiretroviral medicine distribution points, providing access to antiretroviral medicines for people whose health is stable. They collect their medicines every three months and attend a health-care facility once a year for viral load monitoring. This approach has now been broadly adopted in the Democratic Republic of the Congo and funded through the Global Fund and PEPFAR, with 12 community distribution points established in the past year in three priority provinces *(36)*. In Cameroon, a community based distribution scheme for antiretroviral medicines has been adopted similar to the community antiretroviral medicine distribution points.

People living with HIV whose health is stable in Guinea need only attend a clinic every six months for medical consultation, viral load testing and medicine refills *(36)*. This approach reduced staff workload and prevented discontinuation of care among people living with HIV *(37)*. In Nigeria, one-stop shopping clinics have been established in seven states, providing antiretroviral therapy to 12 830 members of key populations.

In 2018, WHO reported that more than three quarters of the western and central African countries surveyed had approved less frequent clinic visits for people receiving antiretroviral medicines whose health is stable, and most provided longer supplies (three, six or 12 months) of antiretroviral medicines *(38)*. However, most countries in western and central Africa do not currently allow community distribution of antiretroviral medicines *(38)*.

Expanding differentiated service delivery strategies appropriate to western and central Africa requires that countries align their policy frameworks with a task-shifting approach (for both children and adults living with HIV) and invest in strong community systems. In the Democratic Republic of the Congo, networks of people living with HIV and community-based organizations play vital roles in the functioning and success of community antiretroviral medicine distribution points *(36)*. In Mali, the nongovernmental organization ARCAD SIDA Mali provides comprehensive HIV care through community care centres, providing HIV treatment to more than half of all people living with HIV. In Nigeria, the Network of People Living with HIV strengthens community links and enhances retention on treatment by coordinating community activities, mentoring, supportive supervision and monitoring of the quality of care, treatment literacy, client tracking, engaging mentor mothers to bridge access gaps for preventing mother-to-child HIV transmission and drop-in centres for members of key populations. Communities have a unique role to play in building demand for HIV testing and treatment services. Harnessing their full potential requires that communities be valued and engaged as critical partners in the HIV response and sufficiently resourced.

Momentum in the region is building to more effectively leverage differentiated service delivery strategies. With the aim of demedicalizing HIV treatment services, Coalition PLUS (a coalition of francophone associations dedicated to responding to HIV) issued clear guidelines in 2017 for achieving the 90–90–90 targets, including implementing differentiated service delivery, with specific recommendations for action from national governments, country coordinating mechanisms, the Global Fund, WHO and UNAIDS *(39)*. A regional workshop in Burkina Faso in February 2018 enabled stakeholders in the region to share information and best practices on differentiated service delivery, and teams have been formed in 19 countries to support the implementation of differentiated service delivery *(38)*. In 2017, UNAIDS facilitated the exchange of information and strategies on differentiated service delivery between stakeholders in Cameroon and the Democratic Republic of the Congo. Sierra Leone is exploring the expansion of differentiated service delivery with the benefit of a situation analysis supported through UNAIDS-facilitated technical support.

Ghana is taking a systematic approach to implementing differentiated service delivery. Led by the national AIDS programme, Ghana is bringing together key stakeholders, including clinics, community health workers, people living with HIV and diverse

international and nongovernmental organization partners. In addition to facilitating the implementation of differentiated service delivery for people whose health is stable, including fast-track clinic visits and six-month prescriptions, Ghana also aims to implement dedicated clinic days for adolescents and undertake focused services for key populations *(38)*.

Strengthen health systems

To effectively manage the care and treatment of people living with HIV, reliable systems must be in place to ensure an uninterrupted supply of essential medicines and other health commodities. Drug stock-outs encourage people to drop out of care systems and discontinue antiretroviral therapy, which in turn leads to HIV drug resistance, higher mortality and the continued transmission of HIV.

Drug stock-outs are all too common in western and central Africa. In 2017, 19% of treatment centres in Cameroon and 18% in Guinea reported antiretroviral medicine stock-outs. In Kinshasa, Democratic Republic of the Congo, one 2016 study found that half of health-care settings had experienced an antiretroviral medicine stock-out in the previous three months *(40)*. Similarly, frequent stock-outs were reported in Congo and for antiretroviral medicines for children in Sierra Leone *(40)*. In 2018, there is concern about the reported possibility of a nationwide stock-out of antiretroviral medicines in Guinea.

These patterns underscore the need to strengthen procurement and supply management systems *(40)*. Drug forecasting capacity must be improved in the region, and sufficiently resourced systems for monitoring drug supplies, including early alert systems, are needed to prevent stock-outs. Clear contingency plans are also required to address stock-outs as soon as they occur and to minimize the period when medicine is unavailable.

Another essential component of health systems—laboratory capacity—is also weak and in adequately resourced in western and central Africa. Several efforts are underway to strengthen laboratory capacity in the region. The Africa Centres for Disease Control and Prevention is launching the Africa Collaborative Initiative to Advance Diagnostics, which aims to advocate for and catalyse access to quality diagnostics for endemic and emergency infectious diseases in Africa. The Joint United Nations Regional Team on AIDS in western and central Africa hosted a four-day capacity-building workshop in 2018, during which participants from 22 countries from the region identified strategies for overcoming laboratory system challenges that impede accelerated biological testing of infants and monitoring of treatment failure. PEPFAR gives priority to technical support for strengthening laboratory systems in its programmes for western and central Africa. In Kinshasa, Democratic Republic of the Congo, MSF developed and the Global

Fund supported an innovative system for transporting viral load testing samples by motorcycles, alongside intensive technical support for implementing viral load testing in 24 health facilities that together serve about 11 000 people living with HIV.

Effectively support civil society action

Civil society organizations are key actors in an effective response as advocates, watchdogs, catalysts for increased service demand and the deliverer of HIV services. Indeed, the engagement and leadership of communities may be the difference between success and failure in national HIV responses, since communities are uniquely positioned to close access gaps for HIV testing, linkage to care, promotion of viral load monitoring, treatment literacy, patient navigation services and re-engaging people who have discontinued care.

Communities know their own needs and the preferences of their constituents better than anyone. Communities have also proven to be essential sources of innovation, including various differentiated service delivery strategies that bring services closer to the people who need them. In Togo, Association des Femmes Amazones (AFAZ), in collaboration with NGO FAMME, is implementing multiple community mobilization strategies to reach female sex workers with HIV services. An observatory, managed by RAS+ (Réseau des Associations de Personnes Vivant Avec le VIH au Togo) and supported by United Nations partners and the national AIDS programme, systematically collects data on instances of stigma and discrimination in Togo. The Cameroon National Association for Family Welfare provides decentralized, culturally appropriate services for men who have sex with men and transgender populations. In Guinea, trained lay counsellors known as *médiateurs* provide HIV testing services and help people living with HIV in navigating health service systems. In May 2018, civil society representatives from 18 countries in the region convened in Senegal to agree on a joint plan of action to harness the power of communities to expedite catch-up efforts in the region *(21)*. Specifically, the joint civil society plan outlines actions and strategies to mobilize sufficient resources, increase demand for services, ensure access to integrated sexual and reproductive health services and promote accountability among all actors in the response.

In western and central Africa, civil society is playing an increasingly prominent role in monitoring access to and the quality of HIV services and human rights barriers to using services. With Global Fund support, civil society groups have joined forces to implement 11 community treatment observatories in western and central Africa. Through these observatories, civil society partners organize regular visits to health facilities to check available stocks of essential medicines, the availability and access to essential laboratory examinations, the provision of care free of charge as stipulated by the government policy or donors and the prevalence of discriminatory practices by health personnel. Their findings, which are reported to the communities, the health-care facilities visited,

the health authorities in charge, donors and other agencies, serve as the basis for immediate mitigation or structural improvements. Both Global Fund and Expertise France Internationale have provided financial and technical support to roll out these observatories.

To play their optimal roles in the HIV response, communities and civil society organizations require sufficient financing and technical support. Just like health systems, community systems and civil society platforms require support in strengthening their capacity and agility in accelerating the HIV response. However, civil society representatives indicate that the value placed on community expertise is weak in the response to HIV in western and central Africa, especially for the delivery of prevention and care interventions *(21)*.

Conclusion

The regional and national catch-up plans offer a historic opportunity to accelerate the HIV response towards 2020 and to enhance the long-term health and development of western and central Africa. We must now build on the new momentum in the region.

The mindset about the approach to the persistently serious HIV epidemic in western and central Africa needs to be changed. Lessons learned from countries in the region that are taking steps to Fast-Track their response and generating encouraging results on the 90–90–90 continuum should be broadly implemented. Mobilizing essential resources is an absolute necessity, demanding increased efforts from both governments and international donors.

Accelerating and sustaining the HIV response in the region will require demedicalizing HIV services and deep structural change to address the root causes of vulnerability and limited service access. Urgent efforts are needed to address the region's weak response to HIV among children, increase the proportion of people who know their HIV status, effectively combat stigma and discrimination, eliminate all user fees for HIV-related services, strengthen health systems and effectively support the essential role of communities and community systems. Although data through December 2017 do not offer evidence of broad-based acceleration in the regional response, the striking success in several countries in removing longstanding impediments to progress demonstrates what is feasible through renewed commitment, evidence-informed action and the active involvement of communities and other stakeholders.

The regional and national catch-up plans offer a strong foundation for a renewed response to HIV in the region. Now is the moment to build on this foundation by taking immediate action to use the tools available to bend the epidemic's trajectory in western and central Africa.

References

1. AIDSInfo [online database]. Geneva: UNAIDS; 2018 (http://aidsinfo.unaids.org, accessed 11 July 2018).
2. Out of focus: how millions of people in west and central are being left out of the global HIV response. Brussels: Médicins Sans Frontières; 2016.
3. Kates J, Wexler A, Lief E, UNAIDS. Donor government funding for HIV in low- and middle-income countries in 2016. Menlo Park (CA): Henry J. Kaiser Family Foundation; 2017.
4. Cameroon country operational plan (COP) 2018: strategic direction summary. Washington (DC): United States President's Emergency Plan for AIDS Relief; 2018.
5. Nigeria country operational plan (COP) 2018: strategic direction summary. Washington (DC): United States President's Emergency Plan for AIDS Relief; 2018
6. IeDEA, COHERE Cohort Collaborators. Global trends in CD4 cell count at the start of antiretroviral therapy: collaborative study of treatment programs. Clin Infect Dis. 2018;66:893–903.
7. Nouboussi J. Implementation of the WCA catch-up plan on AIDS treatment: progress so far and community engagement. International Conference on AIDS and STIs in Africa, 4–9 December 2017, Abidjan, Côte d'Ivoire.
8. Democratic Republic of the Congo country operational plan (COP/ROP) 2018: strategic direction summary. Washington (DC): United States President's Emergency Plan for AIDS Relief; 2018.
9. Waiting isn't an option: preventing and surviving advanced HIV. 2018, Médicins Sans Frontières: Brussels.
10. WHO, United States Centers for Disease Control and Prevention, Global Fund to Fight AIDS, Tuberculosis and Malaria. HIV drug resistance report 2017. Geneva: World Health Organization; 2017 (http://www.who.int/hiv/pub/drugresistance/hivdr-report-2017/en, accessed 11 July 2018).
11. World family planning highlights. New York: Department of Economic and Social Affairs, United Nations; 2017.
12. UNICEF; UNAIDS. Step up the pace: towards an AIDS-free generation in western and central Africa. New York: UNICEF; 2017.
13. UNICEF, UNAIDS. Catalysing paediatric HIV early diagnosis and treatment within west and central Africa country catch-up plans: report of the meeting at ICASA 2017 and Agenda for Action. New York: UNICEF; 2017.

14. United Nations Foundation, Global Fund to Fight AIDS, Tuberculosis and Malaria. Africa scorecard on domestic financing for health. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2017.

15. Expanding the fiscal space for health in Africa. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2016.

16. Dieleman J, Templin T, Sadat N, Reidy P, Chapin A, Foreman K et al. National spending on health by source for 184 countries between 2013 and 2040. Lancet. 2016;387:2521–35.

17. PEPFAR country/regional operational plans (COPs/ROPs) database [online database]. New York: amfAR; 2018 (http://copsdata.amfar.org, accessed 11 July 2018).

18. Moving the needle on grant absorption: insights from Africa's Global Fund implementing countries. Addis Ababa: Africa Constituency Bureau for the Global Fund; 2016.

19. Garmaise D. Global Fund Board approves an HIV grant for Guinea with the Ministry of Public Health as a new PR. Glob Fund Observer. 2018;332 (http://www.aidspan.org/gfo_article/global-fund-board-approves-hiv-grant-guinea-ministry-public-health-new-pr, accessed 11 July 2018).

20. Wright J, Bhuwanee K, Patel F, Holtz J, van Bastelaer T, Eichler R. Financing of universal health coverage and family planning: a multi-regional landscape study and analysis of select west African countries. Washington (DC): United States Agency for International Development; 2016.

21. Compte rendu synthétique de la Réunion régionale de la Société Civivle en AOC sur l'accélération de la mise oeuvre de plan de rattrapage. Ouagadougou: ICI Santé; 2018.

22. Index de stigmatisation et de discrimination des personnes vivant avec le VIH en RDC. Kinshasa: Union Congolaise des Organisations des Personnes vivant avec le VIH (UCOP+); 2012.

23. PLHIV Stigma Index: Senegal country assessment. Dakar: HIV Leadership through Accountability Programme GNP+, RNP+ Senegal; 2012.

24. PLHIV Stigma Index: Cameroon country assessment. Yaoundé-Messa: GNP+, Réseau Cameronais des Associations de Personnes Vivant avec le VIH (ReCAP+); 2013.

25. Bernard E, Cameron S. Advancing HIV justice 2: building momentum in global advocacy against HIV criminalisation. Brighton/Amsterdam: HIV Justice Network, GNP+; 2016.

26. Statement on HIV criminalization in Canada from top Canadian scientists. Vancouver: British Columbia Centre for Excellence in HIV/AIDS; 2017.

27. Carroll A, Mendos L. State-sponsored homophobia—a world survey of sexual orientation laws: criminalisation, protection and recognition. Geneva: International Lesbian, Gay, Bisexual, Trans and Intersex Association; 2017.

28. Chamie G, Clark TD, Kabami J, Kadede K, Ssemmondo E, Steinfeld R et al. A hybrid mobile approach for population-wide HIV testing in rural east Africa: an observational study. Lancet HIV. 2016:3:e111–9.

29. UNICEF, Clinton Health Access Initiative, African Society of Laboratory Medicine, Elizabeth Glaser Pediatric AIDS Foundation, United States Centers for Disease Control and Prevention, WHO et al. Key considerations for introducing new HIV point-of-care diagnostic technologies in national health systems. New York: UNICEF; 2018 (http://www.who.int/hiv/pub/vct/point-of-care-hiv-diagnostic/en, accessed 11 July 2018).

30. Consolidated guidelines on HIV testing services. Geneva: World Health Organization; 2016 (http://www.who.int/hiv/pub/guidelines/hiv-testing-services/en, accessed 11 July 2018).

31. Cartier N, Pestana J, Philips M. Les consequences humaines et financieres des fraid medicaux imputes aux personnes vivant avec le VIH in Guinée, RDC et RCA. 9e Conférence Internationale Francophone VIH/Hépatites, 4–7 April 2018, Bordeaux, France.

32. Zachariah R, Van Engelgem I, Massaquoi M, Kocholla L, Manzi M, Suleh A et al. Payment for antiretroviral drugs is associated with a higher rate of patients lost to follow-up than those offered free-of-charge therapy in Nairobi, Kenya. Trans R Soc Trop Med Hyg. 2008;102:288–93.

33. Taverne B, Karim D, Philippe V. The cost of universal free access for treating HIV/AIDS in low-income countries: the case of Senegal. In: Coriat B, editor. The political economy of HIV/AIDS in developing countries: TRIPS, public health systems and free access. Cheltenham: Edward Elgar; 2008.

34. Grimsrud A, Bygrave H, Doherty M, Ehrenkranz P, Ellman T, Ferris R et al., Reimagining HIV service delivery: the role of differentiated care from prevention to suppression. J Int AIDS Soc. 2016;19:21484.

35. Ferreyra C, O'Brien D, Alonso B, Al-Zomour A, Ford N. Provision and continuation of antiretroviral therapy during acute conflict: the experience of MSF in Central African Republic and Yemen. Conflict Health. 2018;12:30.

36. Towards an increased, more effective care for PLHIV in western and central Africa: dissemination of three novel approaches piloted by MSF. Brussels: Médicins Sans Frontières; 2016.

37. Bekolo CE, Diallo A, Philips M, Yuma JD, Di Stefano L, Drèze S. Six-monthly appointment spacing for clinical visits as a model for retention in HIV care in Conakry-Guinea: a cohort study. BMC Infect Dis. 2017;17:766.

38. Doherty M. Présentations de services différenciés du VIH: parlons—en ensemble. 9e Conférence Internationale Francophone VIH/Hépatites, 4–7 April 2018, Bordeaux, France.

39. Interventions communautaires prioritaires: revendications pour l'atteinte des 90–90–90. Dakar: Coalition PLUS; 2017.

40. Accélérer la réponse VIH en Afrique occidentale and centrale (AOC): une volonté politicque fortemost compromise. Brussels: Médicins Sans Frontières; 2018.

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