Democratic Republic of Congo:
HIV treatment out of reach for majority

In Democratic Republic of Congo (DRC), the outlook for HIV treatment looks particularly grim. Both government and donors have abandoned patients in need, and are in danger of contributing to yet another crisis in an already troubled country.

The Global Fund to Fights AIDS, Tuberculosis and Malaria (GF), which remains the main antiretroviral (ARV) treatment funder in the country, faces not only a shortfall in funding availability, but also important management and disbursement issues that undermine the existing capacity to assure continued treatment and much-needed scale-up.

These funding problems have already undermined patients' access to free ARVs in DRC. While some of the issues at the GF are being addressed, there is a need for additional efforts by the government and by international donors.

However, donors such as US President's Emergency Plan for AIDS Relief (PEPFAR), the World Bank and UNITAID/Clinton Health Access Initiative (CHAI) are limiting or phasing out their financial support for ARV purchase. Meanwhile health donors such as the European Union, its member states and the World Bank have no concrete engagements for the coming years to invest in financial support of ARV treatment. Most have pushed the responsibility for improving ARV coverage onto the GF. However, in a country like DRC, where the context is fragile and the territory is vast, leaving a single donor with the responsibility for essential treatment supplies creates the additional risk that programmes, supply lines, testing and treatment will be interrupted.

DRC's civil society has mobilised to request the allocation of a fair share of domestic resources to effective and free HIV/AIDS treatment. The stakes are high, in particular because of conditions of counterpart financing required by several donors, such as the GF and PEPFAR. Initial reports on the 2012 budget indicate that approximately US$7 million will be allocated to HIV/AIDS, which can be read as an encouraging signal.

Facts and figures

- An estimated 1,000,000 people are living with HIV in DRC. However, because it is not classified as a high prevalence country for HIV, patients in DRC are perceived as less of a priority for HIV/AIDS funding.
- 430,000 people are in urgent need of ARV treatment, but coverage is among the lowest worldwide at 12.3 percent (in sub-Saharan Africa, only Somalia and Sudan have similar rates).
- ARV treatment is available in only 444 health centres across the country, or 11% of the health centres targeted in the national plan.
- Fewer than six percent of HIV-positive mothers have access to ARV drugs to prevent their children from becoming infected.
- Providing care for patients on time is hampered by poor access to health services, a shortage of free diagnostic tests for HIV and CD4 counts, and by people having to pay for healthcare.
- Besides poor access to testing and treatment, efforts to prevent and treat HIV are jeopardised by regular shortages of condoms, laboratory tests, ARV drugs and medicines for treating opportunistic infections.

What is at stake?

- Without significant change, there will be further rationing of treatment initiation, increased risks of treatment interruption (bringing about the need for second-line treatment and hence more costs), and there will be a further decline in the operational capacity of non-governmental treatment providers.

- Because patients cannot access treatment in time, by the time that they arrive at MSF-supported clinics, it is often too late: many are terminally ill and struggling with serious medical complications – a situation reminiscent of the pre-ARV era.

- As funds shrink, the Ministry of Health faces the almost impossible task of implementing the new WHO guidelines, which recommend starting treatment on time and with better drugs. Better suited prevention of mother-to-child transmission (PMTCT) options (B or B+) also remain out of reach.

- The lack of ARV treatment has led to HIV testing being slowed down. The 2010 plan to test more than four million people failed to reach even 300,000 people.

- Without additional engagement by international donors, ARV coverage will remain below 25% in 2015.

- UNITAID's commitment to provide paediatric ARVs will run out by the end of 2012.

- Continuity of treatment for eligible women in the PEPFAR-supported PMTCT programme remains fragile because of the lack of PEPFAR financing of the purchase of ARVs after 18 months. In practice these women need to switch to GF-supported ARV treatment sites in or outside their home areas.

- Financial barriers preventing people from accessing crucial care are likely to increase. Already NGOs that previously provided free ARVs are now asking patients to pay. Meanwhile people must pay US$15 to US$25 to have their CD4 count tested, and cannot start treatment before they find the money. In a country where more than 70 percent of people live on less than a dollar a day, these fees exclude the majority of people with HIV.

- If the GF remains the main and potentially only financial contributor to ARV treatment, programmes and treatment continuity will be extremely vulnerable to disruption.

> ***"It's something of a vicious circle because, to have access to ARVs, you've got to test. But testing isn't available for most Congolese. It should be elementary, whether for the general population or for pregnant women. That's not the case in DRC and, with most of the donors pulling out, I think we are just going to sink into despair."***
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