Aidspan

Independent observer of the Global Fund

HAS THE GLOBAL FUND'S FOCUS ON HIV TREATMENT AND CARE SHIFTED FROM QUALITY TO QUANTITY?

There have been several developments in the response to HIV/AIDS, in particular in the African countries for which we have the most data. We have left behind the period marked by a lack of government initiatives, a time in which associations were the entities investing in prevention, advocacy and even care. The establishment of the Global Fund pushed states to become involved in the response to HIV/AIDS and to make the treatment and care of patients at public health facilities a reality. The pioneering engagement of the community sector, via associations, produced evidence of the necessity of combining community and medical care and treatment for good quality antiretroviral treatment, in order to reduce the viral load of an infected person to a satisfactory level.

However, this evidence seems to have been forgotten and the focus has been on the quantity, rather than the quality, of care and treatment for people living with HIV (PLHIV). Is this a mere assumption or the actual situation? What could possibly justify an option that is so prejudicial to combatting the diseases? What are the obvious consequences?

With respect to the care and treatment of PLHIV, our suspicion that quantity is given greater weight than quality is based on the current indicators in the Global Fund to Fight AIDS, Tuberculosis and Malaria's Modular Framework Handbook, which is used by the Global Fund to organize programmatic and financial information for each grant throughout its life cycle. The only indicators included in the "treatment, care and support" section of the Modular Framework, made public in October 2019, are as follows: percentage of children (under the age of 15) on ART of all children living with HIV at the end of the reporting period, percentage of people on ART of all people living with HIV at the end of the reporting period, and percentage of adults (over the age of 15) on ART of all adults living with HIV at the end of the reporting period.

These indicators concentrate, for the most part, on the number of people on ART and do not provide information on the quality of that treatment. The "care" and "support" parts of the section title have been overshadowed. The UNAIDS and WHO guidelines have always called for holistic care for PLHIV and have suggested combining medical care with community care, which includes therapeutic education services, tracing patients lost to follow-up, and psychosocial support. Combining those services with medical care has always been seen as crucial in terms of ensuring quality follow-up. For example, it is important to know the percentage of PLHIV on ART who are familiar with the treatment regimen, the percentage of appointment attendance, the number of patients lost to follow-up, and the percentage of people receiving psychosocial care, among other things.

Within the "treatment" section of the Modular Framework, there is no mention of biological monitoring, even though it is important to ensure that the biological parameters of patients on ART be monitored, in order to anticipate secondary effects and therapeutic failures. In the same section, the question of ART stock?outs is not addressed. However, community observatories provide sufficient data to show that many patients on ART experience temporary treatment interruptions, which can negatively affect treatment efficacy or even lead to drug resistance.

The main justification for omitting indicators related to community interventions is, in our opinion, not related to reduced awareness of their importance. Rather, it is mainly tied to financial resource issues, including the substantial weight given in the budget to acquiring ART with grant funding. Indeed, the relaxing of conditions for receiving treatment has boosted the number of people on ART, which in turn has resulted in a de facto increase in the drug-acquisition budget. In addition to the increased number of people on ART, 2nd- and 3rd-line drugs have been included in national protocols, the costs of which have remained high, despite the various price decreases that have been announced. Another possible justification relates more directly to community interventions: limited documentation and capitalization of community data combined with a lack of regional and international coordination to support the importance of these indicators and shed light on community interventions.

On the other hand, it is difficult to explain the absence of indicators for biological follow-up and drug stock?outs, especially given the fact that the Global Fund is showing renewed interest in access to treatment observatories. We can understand the concern with avoiding a plethora of indicators, but we note that this concern was not taken into account with respect to prevention.

Our concern about the lack of indicators in the Global Fund's Modular Framework is due to the fact that the organization is the principal donor for national responses to HIV in a number of African countries. All efforts now focus on elements it sees as important, to the detriment of those that have been overshadowed.

One of the direct consequences is a reduction in the weight given to community interventions, which receive less and less funding. Without adequate biological monitoring, the ongoing availability of ART and proper adherence to treatment regimens, there is a concern that even if the second '90' is achieved with

respect to the number of people on ART, the third concerning suppressed viral load may not be.

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