



Independent observer
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ENDING AIDS: MULTIPLE CHALLENGES IN A CHANGING WORLD

As the world observes World AIDS Day on 1 December 2020 with the theme of “global solidarity and shared responsibility” and as the Joint United Nations Programme on HIV/AIDS (UNAIDS) presents the new targets for 2025, it is also a good time to reflect on the challenges to come, from a “global health” perspective. According to [UNAIDS](#), 26 million people living with HIV (PLHIV) were receiving antiretroviral therapy (ART) by the end of June 2019. Although this achievement was unimaginable 20 years ago, [HIV infection today remains the fourth highest cause of death in sub-Saharan Africa](#), while in 1990 it was the seventh highest. How can we explain this situation when we know that today, in countries where access to ART is guaranteed effectively, whether in the north or the south, the life expectancy of a 20-year-old living with HIV is the same as that of someone of the same age who is not infected?

Looking at patient burden of care

Healthy life expectancy is linked to adherence to ART. However, in sub-Saharan Africa, the high rate of those lost to follow-up remains a major problem. In 2014, the Health Care Improvement Project revealed that in Abidjan, after seven months of follow-up, 66 percent of patients were not yet being treated with antiretroviral drugs (ARVs) and [45 percent of patients who started ART were lost to follow-up](#). [The most recent systematic review](#) shows that in sub-Saharan Africa, one third of those lost to follow-up have stopped their treatment, one third have changed health centers on their own initiative, and the last third have died.

Why do PLHIV stop their treatment?

The poor availability of health care providers, the lack of information, the perception of poor-quality service, and the caregiver/patient relationship are among the key factors that PLHIV report to explain why they have stopped their treatment. Studies conducted in [2008](#) and [2009](#) recommended implementing

people-centered strategies, that is, meeting the expressed needs of PLHIV while focusing on the main drivers of retention in care to improve the quality of care. To respond more effectively, we must therefore consider the [“burden of care”](#) for the patient, in terms of time spent to obtain care and treatment, opportunity costs (personal, family, social, and professional costs) and associated expenses: ARVs are free but some services can incur a cost. In Abidjan, for a quarter of the patients, the burden of care was reduced by simply reorganizing the “care pathway”, which generated a saving of 84 minutes of lost time per month and a saving of \$2.90 per patient per month. Aside from the figures, it is important to note that simple arrangements such as spacing out and optimizing visits, and enabling access to community ARV distribution services, can reduce the “burden of care” for the patient and, as a result, the workload for health care staff.

Giving space to mental health and strengthening caregiver/patient relationships

Quality of care is linked to effective communication between patients and clinicians. Transparent, objective and evidence-based communication leads to greater satisfaction, both for the patient and the clinician, and results in better patient adherence to treatment. Unfortunately, the well-being of clinicians is often overlooked and there are few interventions that focus on this. Of the 202 oral presentations (abstracts) from the [AIDS 2020](#) conference, only two covered this topic. In the same way, patients are not sufficiently involved, although they are in a position to come up with ideas to [improve their care pathway](#) and to be partners in improving service quality.

Reintegrating PLHIV into society and seeing them as a driver of social transformation

The response to HIV contributes to achieving several of the Sustainable Development Goals, SDG3 in particular, “Ensure healthy lives and promote well-being for all at all ages.” In terms of national responses, living healthily when you have HIV means achieving the fourth 90, which was proposed by [Lazarus et al.](#) as an additional target ensuring that “90 percent of people with viral load suppression have good health-related quality of life.” From this perspective, individuals are no longer seen as “sick” people, but rather people with a productive role in society. This approach aligns with the World Health Organization (WHO), United Nations, and International Children’s Emergency Fund’s [vision for primary health care](#) in the 21st century, which recognizes: “the essential roles of people and communities as active participants in the creation of health and well-being, through three broad and necessary expressions of empowerment and engagement: as advocates for multisectoral policies and action for health; as co-developers of health and social services; and as self-carers and caregivers”.

Placing the individual at the center cannot be achieved without the commitment of the community system, which is one of the [central pillars to realigning the health system](#). We need to focus on this and consider that achieving the [95-95-95](#) target and the [fourth 90](#) are intrinsically linked. In the long term, this strategy is part of a broader vision to move towards achieving universal health coverage. It is therefore essential to engage actors in the HIV response to have greater focus on the approach led by [Ooms and Kruja](#) on integrating the HIV response into universal health coverage.

Giving people living with HIV a sense of security in their care pathway

[The people-centered approach](#) will make it possible to improve the quality of services by considering the social, economic, political, legal, and geographic vulnerability of service users. It also includes looking at the geographic and financial accessibility of services and their level of acceptability. However, to ensure that individuals will want to use these services, user satisfaction must be considered an essential component: the level of insecurity, confidentiality, and the attitude of caregivers (among others) are determining factors for gauging the benefit that services can offer and for making the benefit greater than potential barriers. Such an approach is carried out through three levels of analysis: daily relationships (microsociology level), major government or inter-government decisions (macrosociology level), and norms, institutions and values (mesosociology level).

Developing a holistic approach to health and disease management

This involves strengthening the resilience of individuals through education about their rights, so that they can assert them and be able to protect themselves. Finally, through initiatives such as support groups and treatment education, individuals will be able to acquire sufficient knowledge to decide and act for themselves, and therefore be able to manage their health care pathway. This approach must be delivered with respect for human rights and with the intention to reduce gender inequalities. This involves reducing stigma related to HIV, or any other disease or disability, social marginalization experienced by certain key populations, discrimination against certain groups on the basis of gender and/or age, behavior, or ethnicity, criminalization of certain sexual and other behaviors, and socio-economic inequalities. Particular emphasis must be placed on gender-based violence, which limits women's access to health services and their ability to protect themselves. Intimate partner violence is often overlooked as it prevents women from demanding safe sex from their partners or accessing HIV prevention and treatment services. Finally, we must not neglect aging and the specific features of old age (which include comorbidities and loss of autonomy).

Confronting systemic issues

Globally, HIV infection is the fourteenth leading cause of death, far behind non-communicable diseases and tuberculosis. Why are the indicators so bad in sub-Saharan Africa while epidemiological transition is taking place on the continent? Is it perhaps simply due to weak health systems? In this case, is it reasonable to think that we will be able to end AIDS, tuberculosis and malaria by 2030 without achieving universal health coverage by 2030, as this requires [resilient and robust systems for health \(RSSH\)](#) to be in place? [Analysis of data from the Africa Dashboard on national health financing](#) and follow-up on the Abuja Declaration in 2001 shows the considerable volatility of budget allocations for health. This means that health systems are unable to achieve the desired level of performance. Data reported through the [Primary Health Care Performance Initiative](#) partnership confirms this. This is why we should celebrate the fact that the Global Fund has followed this direction by investing more than \$1 billion each year in catalytic interventions to develop health systems using the 4S model: Start-up, Support, Strengthening, Sustainability. On this basis, each country can assess the development of its health system and identify the limitations that may have an impact on the HIV response.

Redefining the role of the HIV response in a globalized world

One must not forget how the world has evolved and has become more globalized since the discovery of HIV. This has resulted, among other things, in considerable changes in health governance with non-governmental stakeholders, such as philanthropic foundations, international non-governmental organizations, the private sector (pharmaceutical laboratories, mobile phone operators, Big Data and artificial intelligence), and local government becoming increasingly powerful. In this context, the response to recent crises, such as Ebola, Zika and SARS-CoV-2, have revealed challenges for the WHO to lead [a global response](#). In this new governance context, health decisions are no longer taken at national level,

but at global level and diplomats play a key role in managing global health crises, as they can serve as a gateway to peace talks between countries. We have entered the era of “health diplomacy”. The coronavirus disease 2019 pandemic (COVID-19) has amplified this, with the withdrawal of the United States from the WHO (seeking scapegoats in the WHO and China) and the frantic race for a vaccine (which, on the premise of research initiation, high-income countries have bought millions of doses of). In addition, we have not yet measured all the consequences of this pandemic, and in particular social crises in the North, with a large number of countries going into economic recession. For example, the [United Kingdom has announced it will reduce its official development assistance from 0.7 percent of GDP to 0.5 percent.](#)

Today, we must ask ourselves: “what is the role of the HIV response in the context of health diplomacy?” While also considering the changing priorities of donor countries: lifestyle-related diseases (cancer, obesity, diabetes, etc.), climate change and migrant crises.

Constantly adapting to an ever-changing world

During the COVID-19 crisis, we have witnessed media hype and information overload about science, increased “digitization” of society in the North and growing development of the “digital age” in the South. As new tools appeared, it was urgently necessary to develop new skills in remote working, telemedicine, distance education to respond to those tools, which has led to two worlds coexisting: the digital world and the real world. Through the media and social networks, information—whether it be reliable and evidence-based or false and “conspiratorial”—is shared at a phenomenal speed, making it difficult to manage a health crisis. The [WHO](#) call it an [infodemiology](#). This societal change is already having repercussions on the HIV response, with a large number of countries in the South including “digitization” of health in their Global Fund funding requests, although they are not prepared for it. There is a significant risk that this will lead to a greater [fragmentation of the health system](#), the opposite to the desired result.

Building the future through lessons learned from the HIV response

Let’s take a look at climate change as an example. Its impact in the South has already been seen in greater heat episodes and abundant rains. This can lead to increasing numbers of particular species of mosquitoes and diseases associated with them, increasing food insecurity and population displacement. Are the SARS coronaviruses and the Zika virus not an indirect consequence of these disturbances, meaning that changes to the ecosystem have allowed these viruses to cross from one species to another? Therefore, in the short term, health and community systems will need to be robust and resilient enough to absorb these shocks. By strengthening community systems involved in the HIV response, countries will contribute to the development of networks that can play a major role in the response to epidemic-prone diseases linked to climate change, thanks to their experience from the HIV response. It would be far simpler to mobilize community stakeholders to engage in detection and early warning, prevention, and care. At the same time, these community stakeholders can take part in strategic reflections around local public health decisions to weigh up the immediate health benefits of a policy and the impact on future generations.

Where are we heading?

In conclusion, the HIV response has always been able to innovate to meet technical and social challenges. Each country now has powerful tools for diagnosis, access to effective ART, and viral load monitoring. Each country is committed to upholding human rights and fighting against gender inequalities. Each country is committed to changing its community and health systems to move towards universal health coverage and make HIV infection a chronic disease. But there are still new societal challenges to be met, linked to global health governance, digitization, health crisis management linked to climate change, among others. To achieve this, more than ever, the world needs both a strong [WHO](#) and human-

centered interventions that are tailored to the local context. Let us reflect on Albert Einstein's words: "Insanity is doing the same thing over and over again and expecting different results."

Further Reading

- [Outcomes of HIV-positive patients lost to follow-up in African treatment programmes. Trop Med Int Health](#)
- [Successes, challenges, and limitations of current antiretroviral therapy in low-income and middle-income countries. The Lancet Infectious Diseases. 2009](#)
- [Early loss of HIV-infected patients on potent antiretroviral therapy programmes in lower-income countries. Bulletin of the World Health Organization](#)
- [Avoidable workload of care for patients living with HIV infection in Abidjan, Côte d'Ivoire: A cross-sectional study.](#)
- [International aids society. Abstract book. 23rd international AIDS conference; Virtual2020](#)
- [Patients' perspectives on how to decrease the burden of treatment: a qualitative study of HIV care in sub-Saharan Africa](#)
- [Beyond viral suppression of HIV – the new quality of life frontier. BMC medicine. 2016](#)
- [The World Health Organization and United Nations Children's Fund \(UNICEF\). A vision for primary health care in the 21st century. Towards universal health coverage and the sustainable development goals](#)
- [Reorienting health systems to care for people with HIV beyond viral suppression. The Lancet HIV. 2019](#)
- [The Joint United Nations Programme on AIDS \(UNAIDS\). Fast-Track – Ending the AIDS epidemic by 2030](#)
- [The integration of the global HIV / AIDS response into universal health coverage: desirable, perhaps possible, but far from easy. Globalization and Health. 2019](#)
- [The Global Fund. Building resilient and sustainable systems for health \(RSSH\). Information note. 2020](#)
- [The Global Fund. Technical evaluation reference group: position paper – thematic review on resilient and sustainable systems for health \(RSSH\). 2019](#)
- [The Primary Health Care Performance Initiative. Vital signs profiles](#)
- [COVID-19 cacophony: is there any orchestra conductor? Lancet \(British edition\)](#)
- [How to Fight an Infodemic: The Four Pillars of Infodemic Management. Journal of medical internet research. 2020](#)
- [Framework for Managing the COVID-19 Infodemic: Methods and Results of an Online, Crowdsourced WHO Technical Consultation. Journal of medical internet research. 2020](#)
- [Santé numérique en Afrique subsaharienne francophone: rattraper le retard! Medecine et sante tropicales. 2017](#)
- [The WHO we want. Lancet \(British edition\). 2020](#)

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