19th ICASA CONFERENCE 2017 - HIGHLIGHTS

ABIDJAN, CÔTE D'IVOIRE

The Clinton Health Access Initiative (CHAI) supported three AfroCAB advocates to attend the ICASA 2017 conference. Here is the feedback after the conference by the advocates. It is in accordance with that arrangement that we submit this merged report, which outlines some of the highlights of the conference, 2 – 10 December 2017.

Report by George Kampango (Malawi), Salim Kibet (Kenya) and Olubukola Ayinde (Nigeria)

INTRODUCTION

The conference theme "**Africa: Ending AIDS-delivering differently**" engages the whole continent and all stakeholders in the post SDG framework, where sustainability of the response in reaching 90, 90, 90 of UNAIDS will not be possible if Human rights are not key priority for a new vision of leadership in the context of strengthening the application of science based evidence.

The 19th ICASA is an opportunity to renew this global commitment by drawing the world's attention to the fact that the legacy is now under threat as a result of the global economic downturn. This year's ICASA is an opportunity for the international community, and all Africans, to join efforts in committing to achieving an AIDS-free Africa. Given the urgency of the issue we are anticipating 7 000 -10 000 of the world's leading scientists, policy makers, activists, PLHIV, government leaders – as well as a number of heads of state and civil society representatives – joined the debate on how to achieve this vision.

The conference was chaired by Dr Ihab Abdel Rhaman Ahmed, an epidemiologist and President of the Society for AIDS in Africa (SAA). It was co-chaired by Dr. Raymonde Coffie Goudou, Ministry of Health representing the Government of Côte d'Ivoire.

The conference was an excellent opportunity to promote inter-sectorial achievements in the AIDS response and to strengthen the partnership among governments, civil society, and development partners.

ICASA 2017 OBJECTIVES:

- Promote innovation, partnerships to increase domestic investments to achieve 90/90/90 targets
- Integrate approaches for sustainable Responses towards ending AIDS, TB, Hepatitis and associated diseases
- Translating science into action to maximize programme impact
- Provide a platform to Maintain and Sustain Investment for CSO and FBO's
- Provide a platform to promote rights-based models to overcome structural and policy barriers towards universal access.

OFFICIAL OPENING SESSION

Opening ceremony witnessed series of speeches. Highlights of the speeches include:

- Exactly 20 years ago ICASA was held in Cote D'Ivore.
- A minutes silence was observed in honour of all the youths who had not survived HIV
- HIV is yet to be defeated.
- We must redouble our efforts and not allow ourselves to lose our gains.
- PMTCT coverage has increased; Uganda, Zimbabwe, South Africa and Botswana are doing well with 9 out of 10 pregnant women receiving PMTCT services.
- We need to intensify prevention efforts: New infections highest in young girls, we have obligation to protect young girls and women especially in Sub Saharan Africa.
- HIV infection higher in young unmarried women compared to their married counterpart.
- We must accelerate programmes geared towards adolescents to enable them make right choices.
- Families to provide contusive environment to protect children from infection.
- Men are not been tested and they are not using prevention services.
- We need to recheck discrimination: exclusions are still current practices in clinics and streets.

- Vulnerable communities have gone into hiding; we need to take HIV out of hiding.
- 75% of children living with HIV are not receiving treatment in Africa.
- We need not just do vertical programmes but build bridged with other programmes e.g. TB, cancer.
- West and Central Africa are missing the target.
- With budgetary cuts CSOs will lose its role: There is need to inject dynamism into the roles of CSOs and put them at the centre of the fight.
- Mobile and Internet are technology that can help increase access to information and referrer to service centre.
- We must review response to renew commitment of leaders, donors and countries.

"To be born with HIV is not our responsibility; to remain safe and uninfected is your responsibility: provide appropriate services for youths/adolescents." – Youth speaker at opening ceremony

The President of Cote d'Ivoire

- HIV continues to be a concern because it is impacting negatively on economic development.
- Countries need to re-define their policies in responding to HIV and AIDS.
- My government would like to lower the HIV prevalent rate from 2.6% to 1%. Migration needs to be monitored and controlled; so too, stigma, discrimination and the Ebola epidemic.
- I would like to commend the prevailing solidarity among civil society organisations and the donor community for their relentless work in responding to the various health conditions. My government is committed to improving the quality of life for people living with HIV.

Dr. Raymonde Goudou Minister of Public Health and Sanitation in Cote d'Ivoire

- Patients are in the south: Medicines are in the north.
- Health is a right: Ending AIDS is a responsibility for all

"I would like to wish you the traditional ***''Akwaba'' (welcome)*** *in our beautiful country, Cote d'Ivoire. Choosing Cote d'Ivoire as the host country for ICASA 2017 is a strong signal of the Government commitment to end HIV/AIDS pandemic. The country is one of the most affected countries by HIV and AIDS in West and Central Africa (WCA).*

The commitment of the Ivorian government led to significant progress towards achieving 90-90-90 targets. Cote d'Ivoire now offers immediate access to treatment to anyone diagnosed HIV positive, (Screen and treat) which should stimulate progress towards the achievement of 90-90-90 targets.

I would also like to take this opportunity to praise governments and the international community efforts. These promise a better horizon for achieving the 2030 goal established by UNAIDS and which aims at ending HIV/AIDS. An objective to which Cote d'Ivoire adheres.

Beyond the efforts of the rulers, our populations must also commit themselves for ending HIV because « the end of HIV » also means raising awareness and putting preventive measures into practice; the adoption of attitudes, habits and simple gestures which maintain us in good health. I therefore urge all the populations through the concept ***''Ma santé, Ma Vie''*** *(My health, my life) to appropriate the preventive measures and to get tested in order to know their serological status.*

*Finally, I would like to reiterate the thanks of the Ivorian government which is happy and proud to welcome you and ask you to support the Ministry of Health and Public Hygiene and the Society for Aids in Africa for a successful ICASA in the evening of 9th December which theme is "****Africa: Ending AIDS-delivering differently****".*

- Sub Saharan Africa remains the most severely affected continent due to the ravage being caused by HIV.
- The health of our nations depends on the health of the people.

Professor Michel Sidibe

- I commend civil society organisations for their activism. Without you there would not be any meaningful response to HIV.
- Countries need to inject dynamism into the response
- Protect young girls and women from exposure of HIV infection and child marriages
- Check stigma and discrimination especially in health clinics;
- Promote universal access in clinics because it is vital
- Double standards should be avoided in the response, especially in treatment access for children
- Governments should reduce dependence on donor funding and embark on domestic financing, increasing budget allocation for treatment
- Remove isolation from HIV response; break the barriers that impede success of programmes

SHARING EXPERIENCE OF LIVING WITH HIV

Sharing her experiences of living with HIV, a young girl (*name withheld*), 20 years old, informed the conference that when she learnt about her HIV positive status she was worried. She said it was shocking to learn that 90% of African children die due to lack of treatment. However, she was lucky that in 2008 she started antiretroviral therapy, which has given her all the strength and energy that has kept her alive throughout.

Her mother died in 2003 and she has grown up with her grandparents who have provided all the support she needed over the past ten years.

While calling on countries to commit to supporting the young people to prevent HIV infection, which she said was everybody's responsibility; she also encouraged fellow young people to fight for survival, and not letting HIV hinder the response.

ACTIVISITS VOICES

On day 1 (4 Dec) during a session hosted by the World Health Organization, ITPC MENA and allies called on the Clinton Health Access Initiative (CHAI), Gates Foundation and others to increase access to Dolutegravir, which presents an new optimal HIV treatment. A pricing deal announced in September omits 29 countries, meaning millions could be left behind from treatment advances and the improved quality of life that brings.

Marching for Algeria! On 5 December, led by ITPC MENA and the Regional Treatment Observatory in West Africa, activists drew attention to the fact that ViiV Healthcare has excluded Algeria from a voluntary license which includes all other countries in Africa. It's an issue that ITPC MENA has been discussing with ViiV for two years to no avail. We urge the government of Algeria to issue a compulsory license that would accelerate access to the drug.

Access Denied. Hotel and conference security prevented activists from entering the venue both during the demo and up to five hours later. The conference is dedicated to tackling the region's HIV epidemic, and community voices are key to the solutions, so it absurd to ban activists, not least when they're campaigning on how access is being denied to people living with HIV.

Above: activist barred by the Ivorian military personnel from entering the Sofitel Hotel.

Media attention. A joint statement issued by more than 20 civil society organizations was presented to the conference organizers urging for this to never happen again, and the media in Algeria picked up the story and reported on the points behind the protest.

Watch What Matters. On day 3 (6 Dec) participants gathered at the Treatment Networking Zone, hosted by the regional Community Treatment Observatory in West Africa for a community dialogue. Sessions in this zone covered a range of treatment access issues, including intellectual property and community monitoring.

Assess your law. ITPC MENA gave an oral presentation on the assessment it has carried out in Egypt, Morocco and Tunisia, on the intellectual property landscape and its impact on access to medicines. The tool used can also be replicated so people in other countries can assess their context and benchmark against other countries that do the same.

FROM TREATMENT NETWORKING ZONE

Above: Kenly Sikwese, AFROCAB Coordinator speaking on Treatment Optimisation through a French interpreter sitting in the middle (between Obatunde and Kenly Sikwese).

It was clear from the networking zone that there is need to prioritize people's health not wealth.

Role of community in Treatment Optimization (Kenly/Obatunde)

They must participate in the process of defining appropriate demand generation activities and raise issues that will affect successful implementation of Treatment optimization.

Prepare the community by disseminating ARV treatment literacy messaging and knowledge and work with other key stakeholders like the media, Psychological and retention officers, Clinicians, policy makers, Fellow PLHIVs, and treatment working groups. Importantly they help develop and distribute treatment literacy materials.

"*We do advocacy at National, Regional and Globally on issues that directly affect PLHIVs and a good example is the Demand creation of the use of DTG in LMIC and Kenya has shown a success since it started the roll out in Three regions Namely Eldoret, Nairobi and Kisumu Site and all who were on 3TC/TDF/NVP are switched to 3TC/TDF/DTG and is targeting 22,000 Patients by the end of 2017 and a full roll out to commence by the end of June 2018.This is actually The power of advocacy that is evidence best thus convince the MOH resulting to complain from MOH that the demand of DTG in Kenya has become a headache to the entire ministry of health*".

Kenly said that *advocacy is and was a game changer and a game of numbers but the type of information matters for any advocacy to achieve its goal. You need the right people, number analysis, understand what you need and who are friends/enemies (policy makers), and map stake holders*.

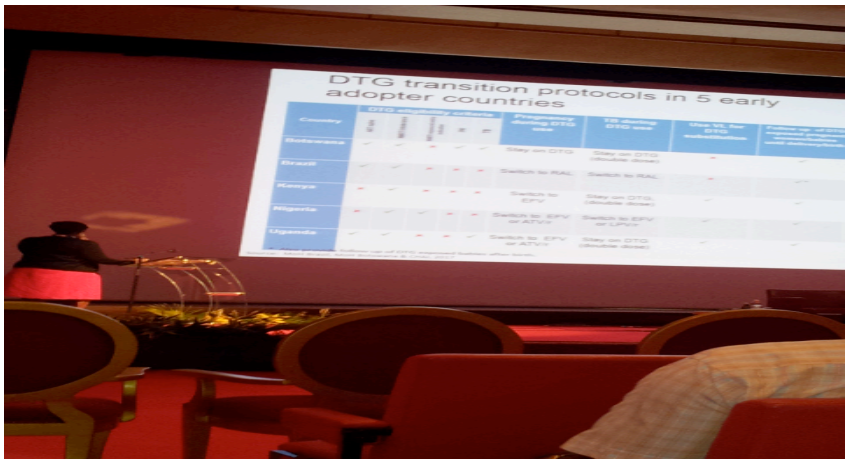
The community representation at the global platform is always encouraged to mobilize the National network of PLHIVs at countries level, make the have knowledge on TO and foster community dialogue. "PUT THE BEST FOOT FORWARD"

Are you RESISTANT TO YOUR HIV DRUG?

Ask your doctor to SWITCH you…
TO Dolutegravir (DTG)!

It is efficacious, affordable, non-toxic, less side effects, tolerable…

HIV drug resistance (HIVDR) poses a potential threat to the long-term success of ART and to the elimination of AIDS as a public health problem. While the implementation of the WHO Test and Treat will reduce the number of new HIV infections, acquired HIVDR in treated individuals and transmitted HIVDR in newly infected individuals may also increase.



EARLY ADOPTERS OF DTG

- The five early adopters of DTG are Botswana, Brazil, Kenya, Nigeria and Uganda.

- Access to Dolutegravir necessary to end AIDS; say countries and civil society. On 5 December 2017 – Global partner organizations echoed strong support for scale-up of Dolutegravir (DTG) use in countries WHO Coordinator for HIV Treatment and Care, Dr Meg Doherty, opened the session by providing an overview of WHO's new guidance on DTG. This included guidance for when HIV drug resistance to first-line treatment containing efavirenz (EFV) reaches 10% among people starting antiretroviral treatment. She also highlighted DTG's potential impact among adolescents and other populations, as it has a high barrier to the development of resistance and few side effects.

- Dr. B. Nkomo, Head of Programmes for the Botswana Ministry of Health, presented an analysis of the economic and programmatic implications of DTG rollout in his country. The analysis predicted greater reductions in new infections and fewer deaths among tuberculosis patients. "By using DTG, we can implement our 'treat all' policy as early as 2018, and achieve HIV epidemic control by 2020," According to Dr Nkomo, Botswana is experiencing challenges such as shortages in human resources and difficulty maintaining a reliable supply chain for medicines.

Nevertheless, the country is committed to switching all patients to DTG between 2017/2018, and will develop a nationwide communication strategy to raise public awareness. While the introduction of DTG is benefitting many patients in pathfinder countries, generic pediatric formulations are still not available. Dr Martina Penazzato, WHO's pediatric HIV focal point, expressed hope that such formulations will become available soon. She referred to a new plan of action agreed by partner organizations to accelerate progress in this area.

- Dr George Siberry, representing the US President's Emergency Plan for AIDS Relief (PEPFAR), shared the perspective of the largest donor agency for HIV treatment programmes. PEPFAR is focusing on a country-by-country rollout approach following strong national leadership. The programme prioritizes rollout of the fixed-dose combination of Tenofovir, Lamivudine and Dolutegravir (TLD); however, PEPFAR recognizes that this will take some time, as counties need to ensure proper use of all existing stocks of EFV-based HIV treatment regimens.

- The session also included presentations from global partner organizations the Clinton Health Access Initiative (CHAI) and UNITAID which are making great strides in enabling country access to DTG. CHAI negotiated a global agreement for affordable pricing of generic DTG at US$ 75 per patient per year, which is hoped to ease country decision-making for access in 92 low- and middle-income countries.

- Civil society advocates from the International Treatment Preparedness Coalition (ITPC) stressed the strong role communities will play in treatment education and scale-up of DTG use. They expressed support for the new CHAI-led agreement for wider DTG access, but also dismay that some countries in the region have not been included in the agreement.

- "*We want DTG for ALL regardless of which communities we come from, or which countries we live in. Fix the deal to make sure it benefits everyone*," ITPC said via twitter.

Highlights

Sustainable Funding: Domestic financing, ending AIDS:

- The dwindling and unpredictability of development assistance compels Africa to look inward to domestic resources for the care of her people.
- Investment in health is investment in wealth
- Health financing, health system performance and economy growth will reduce burden on families.
- Africa heads need to invest in health to achieve 2030 target and 2063 framework.

Key Population: Key for ending AIDS:

- 90:90:90 targets –they make up the 10% left behind
- Key population needs more attention
- They are worried that domestic funding may not be available to key population
- Local facilities may not provide for them
- Global investment and regional programs are still important to make progress.

What are we not doing?

- Lack of investment in KP community structure
- Not enough interventions are done

- Arrest of KP (e.g in Tanzania, there was illegal arrest)
- Increasing hostility based on sexual identity,
- Not enough investment (e.g Prep for KP)
- Inequalities and discrimination in access to health
- Young key populations: doubly excluded and left far behind.

What to do:

- Remove barriers that are holding back progress in AIDS response such as punitive laws, prosecutions, policies and practices that blocks access to HIV services
- Consider KP as human being beyond the disease.

STIGMA AND DISCRIMINATION: A STRUCTURAL BARRIER TO ACCESS TO SERVICES AND RIGHTS (PLENARY SESSION)

Structural barriers are prejudice that blocks access to right and institution, yet Very little data is available on prevalence and impacts of stigma (no effective data in Africa), this makes it impossible to access resources to address it.

UNDERLYING CAUSES

- Perception of communities about HIV transmission (sexual means)
- Taboo surrounding blood
- PLWHIV self stigmatizing themselves

INSTITUTIONAL BARRIERS

- Lack of policy on stigma and discrimination
- Lack of information by service providers
- Discriminatory laws (homosexuality and sex work criminalization)
- Limited mechanism for dealing with stigma and discrimination (inadequate legal instrument)

WHAT SHOULD WE DO

1. Putting structures in place to document stigma and discrimination
2. Make adequate resources available to address stigma and discrimination
3. Put policies in place and monitor

UNAIDS PROPOSE

- Training HCW in respect of ethical training and human rights taking into consideration issue of discrimination in health system
- Legal talk to communities about their rights and legal consultation
- Sensitization of legislators, police, parliamentarians and prison officers
- Surveillance and legislative reform,
- Evaluation of access to justice and advocacy.

OPTIMIZING HIV TREATMENT ACCESS (OHTA)

The OHTA was conducted in Malawi, Uganda, DRC and Cote d'Ivoire and it was aimed at PMTCT optimisation implementation with the support of UNICEF: optimizing HIV treatment access for pregnant women initiative (2013 - 2017). All the four countries achieved significant progress on PMTCT since 2013.

Lessons learnt

Relevance

The OHTA funding addressed important gaps in demand creation, community-facility linkages and data quality. It also raised the profile of these aspects of Option B+ implementation and catalyzed greater focus by other partners. Involving districts from the outset was strategic in generating buy-in and a faster speed of implementation.

Effectiveness

Initiatives funded though the OHTA grant contributed to increases in male involvement in PMTCT, couples HIV testing and counselling, ANC attendance, pregnant women tested and initiated onto lifelong treatment and, facilitated the use of data for management and client tracing and retention in care. In Malawi in particular, OHTA has enabled increased emphasis on district and facility level data management including facility level data reviews and using data for monitoring effectiveness and for planning future activities.

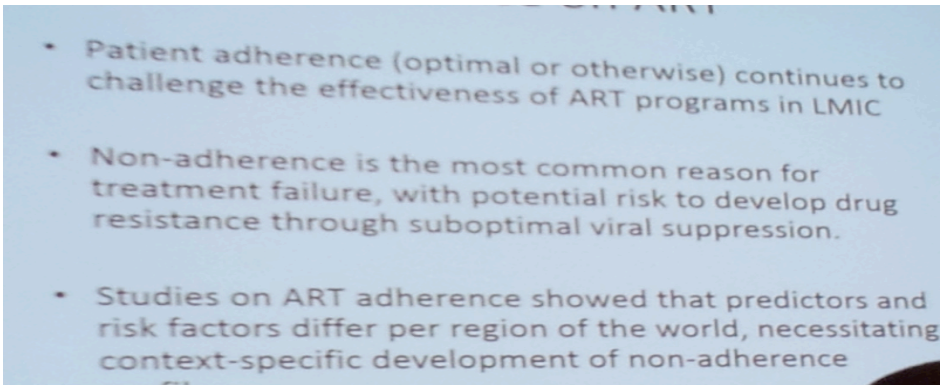
A receptive environment for policy change, strong leadership by the Ministries of Health, and effective collaboration and communication between partners helped the OHTA grant achieve programme objectives and ensured a complementarities of services with other partners. Working through the districts for programme implementation fostered a sense of ownership of the programme at the local levels and contributed towards a culture of regular data informed policy assessment and recourse.

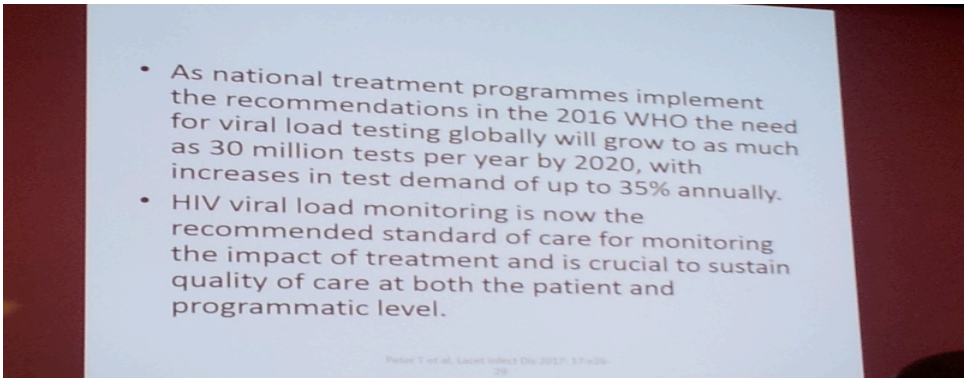
Increased efforts are needed to improve timely antenatal attendance within the first trimester as well as coverage of EID which is currently at around a quarter of expected HIV exposed infants. Retention monitoring systems are still new a little data exists to assess the effectiveness of strategies to improve retention in care.

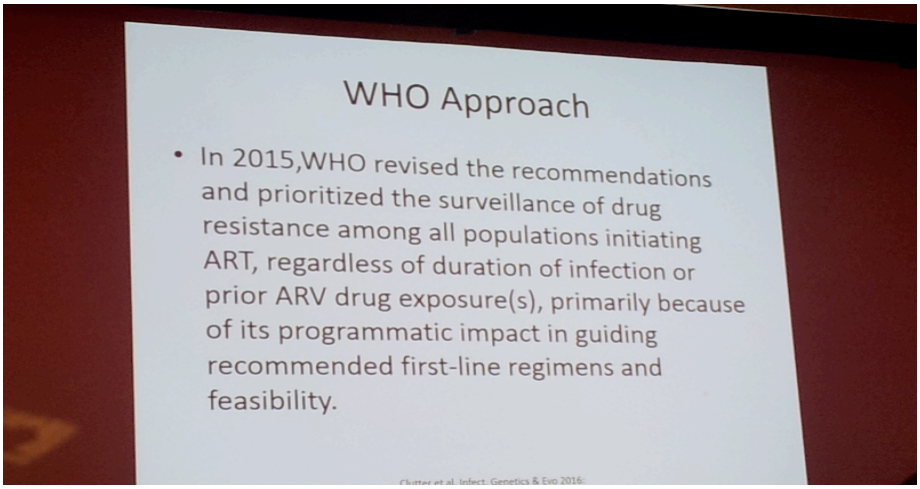
Sustainability

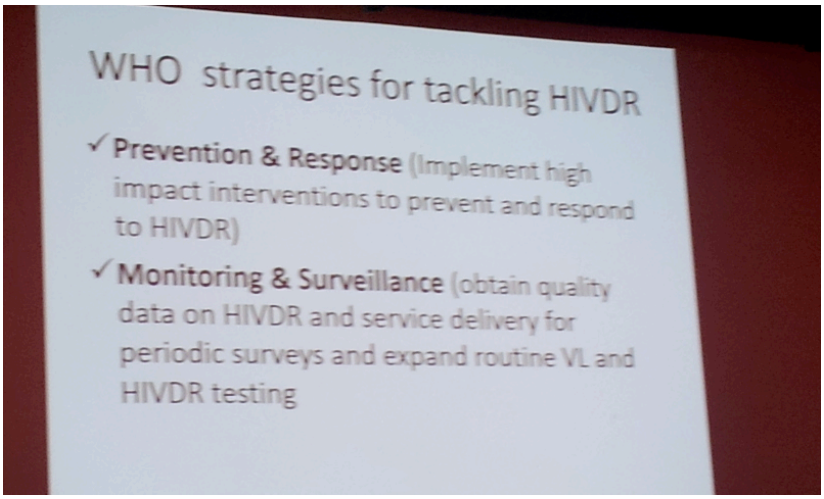
OHTA funding has led to the establishment of community involvement in PMTCT through the use of various community cadres (CHWs, mentor mothers etc.). These initiatives, although drawing largely on existing cadres, require ongoing funding to support the additional community-facility linkage activities.

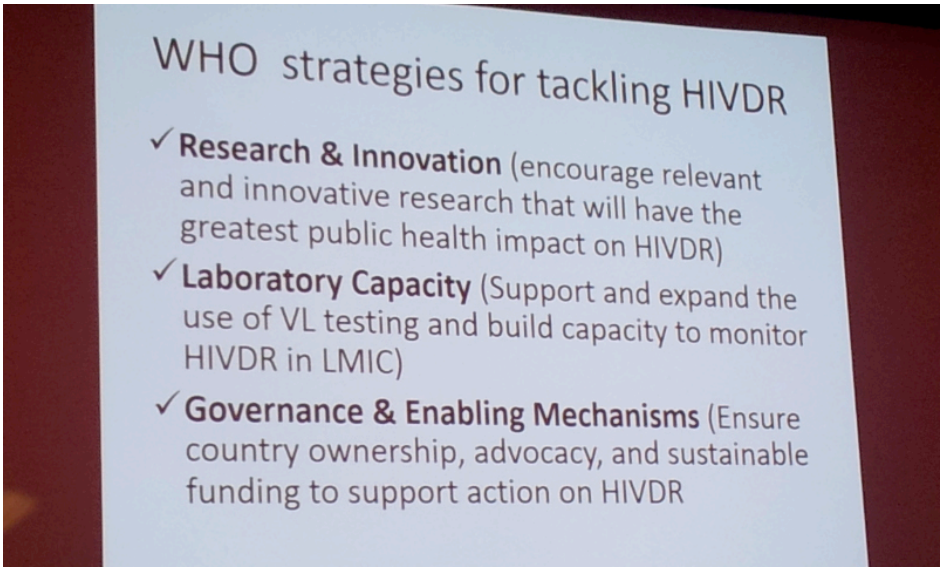
ART ADHERENCE




• As national treatment programmes implement the recommendations in the 2016 WHO the need for viral load testing globally will grow to as much as 30 million tests per year by 2020, with increases in test demand of up to 35% annually.
• HIV viral load monitoring is now the recommended standard of care for monitoring the impact of treatment and is crucial to sustain quality of care at both the patient and programmatic level.


WHO Approach
• In 2015,WHO revised the recommendations and prioritized the surveillance of drug resistance among all populations initiating ART, regardless of duration of infection or prior ARV drug exposure(s), primarily because of its programmatic impact in guiding recommended first-line regimens and feasibility.

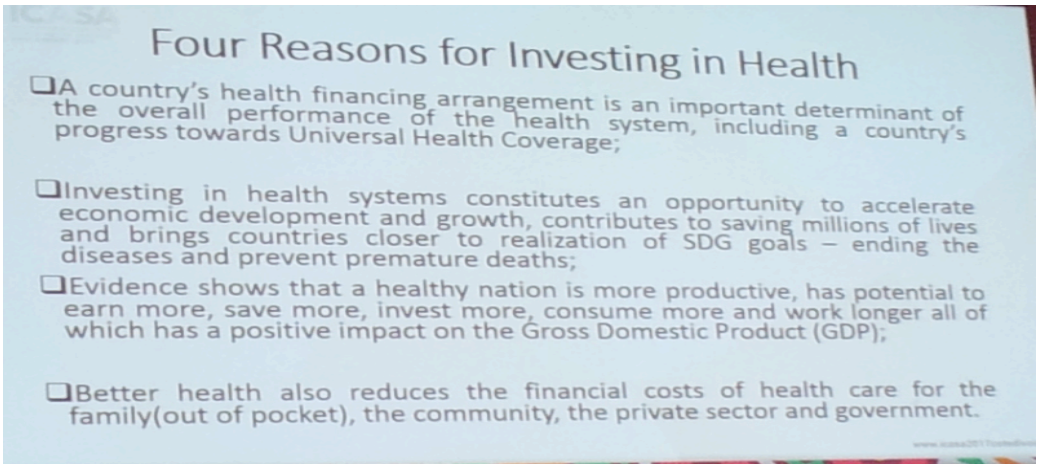

WHO strategies for tackling HIVDR
✓ Prevention & Response (Implement high impact interventions to prevent and respond to HIVDR)
✓ Monitoring & Surveillance (obtain quality data on HIVDR and service delivery for periodic surveys and expand routine VL and HIVDR testing


WHO strategies for tackling HIVDR
✓ Research & Innovation (encourage relevant and innovative research that will have the greatest public health impact on HIVDR)
✓ Laboratory Capacity (Support and expand the use of VL testing and build capacity to monitor HIVDR in LMIC)
✓ Governance & Enabling Mechanisms (Ensure country ownership, advocacy, and sustainable funding to support action on HIVDR


"The dwindling and unpredictability of development assistance compels Africa to look inwards for domestic resources for the care of her people.
Africa will need to mobilize internal resources for the promotion of her health"
Aspiration-1: A prosperous Africa based on inclusive growth and sustainable development;
-Agenda 2063: Strategic Framework

Health financing advocacy voices

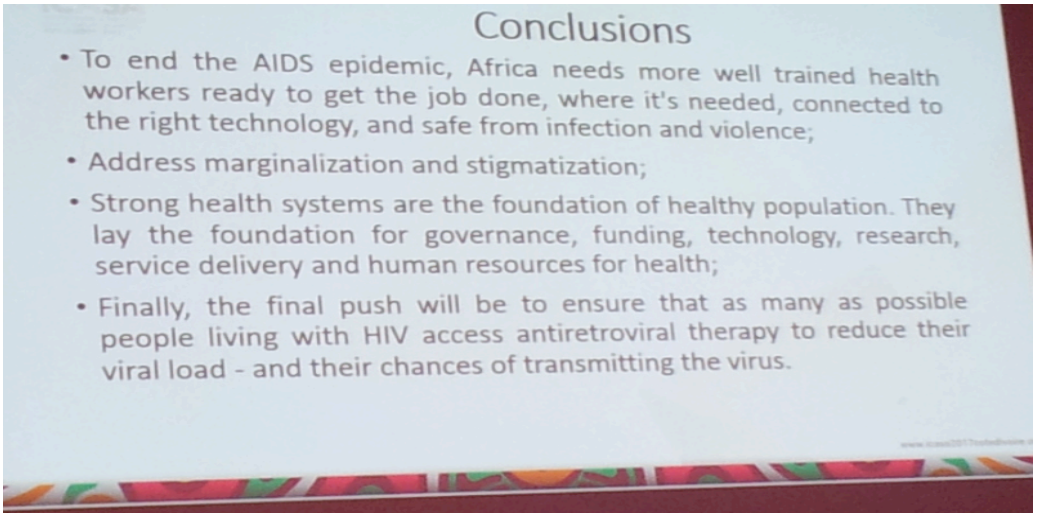
"Investment in Health is investment in economy"
"We do not want wealth, we want health" – George Orwell



In the SDGs and Agenda 2063 era, there is a call not only for increased investment in health but the centrality of ensuring that invested resources yield more value for money, efficiency gains, and optimisation of resources, sustainability and accountability.

This trajectory is a solid policy direction that provides enablers for transformative actions translating commitments into health deliverables and respond to the multifaceted and complex health needs for countries.

Removing uncertainties regarding health financing ushers in stability and predictability and improves planning as well as execution of health programmes leading to multiple efficiencies culminating to high-end impact.



Mr. Ishmael Nyasulu of WHO Malawi at ICASA 2017, Abidjan, Cote d'Ivoire

"Malawi is following the discussion on DTG with keen interest, and considering the transition to DTG but most likely sometime next year" - Nyasulu

Western and central Africa catch up plan

Under the leadership of countries and regional economic communities, and in collaboration with UNAIDS, the World Health Organization, Doctors Without Borders and other partners, the catch-up plan in western and central Africa, started implementing in late 2016, seeking to dramatically accelerate the scale-up of HIV testing, prevention and treatment programmes, with the goal of putting the region on the Fast-Track to meet the 90–90–90 targets by December 2020.

- 57% of all people living with HIV knowing their HIV status,
- 46% of all people living with HIV accessing treatment and
- 38% of all people living with HIV virally suppressed by2015, the western and central Africa region lags behind, achieving only 36%, 28% and 12%, respectively, by 2015. The gap is considerable even though 4.7 million people living with HIV are not receiving treatment, 330 000 adults and children died from AIDS-related illnesses by 2015.

The catch-up plan was aimed to increase the number of people on treatment from 1.8 million to 2.9 million by mid-2018, giving an additional 1.2 million people, including 120 000 children, access to urgently needed treatment.

The first call for a catch-up plan for the region was made at the United Nations General Assembly High-Level Meeting on Ending AIDS in June 2016. Since then, at least 10 countries (Benin, Cameroon, the Central African Republic, Côte d'Ivoire, the Democratic Republic of the Congo, Guinea, Liberia, Nigeria, Senegal and Sierra Leone) have developed country operational plans deriving from the western and central Africa catch-up plan with a focus on ensuring the needed policy and structural changes.

Two million community health workers

The community health worker initiative aims to accelerate progress towards achieving the 90–90–90 targets by 2020—whereby 90% of all people living with HIV know their HIV status, 90% of people who know their HIV-positive status are accessing treatment and 90% of people on treatment have suppressed viral loads—and to lay the foundation for sustainable health systems.

Championed by the President of Guinea and African Union Chair, Alpha Condé, the initiative seeks to confront the acute health workforce shortages across Africa and improve access to health services for the most marginalized populations, including people living in rural areas.

Substantial evidence, from both Africa and elsewhere, demonstrates that well-trained, properly supervised community health workers provide an excellent quality of care and improve the efficiency and impact of health spending. Community health workers have helped devise some of the most effective service delivery strategies for HIV testing and treatment. Studies have also linked community-delivered services with increased rates of immunization, exclusive breastfeeding and malaria control coverage.

UNAIDS estimates that there are more than 1 million community health workers in Africa today, but most focus on a single health problem and are under-trained, unpaid or under-paid, and not well integrated in health systems. The new initiative endorsed by AIDS Watch Africa seeks to retrain existing community health workers, where feasible, and to recruit new health workers to reach the 2 million targets.

While community health workers may hold the key in many settings to achieving the 90–90–90 targets, the benefits of this new initiative extend well beyond the AIDS response. The initiative has expedited gains across the health targets of Sustainable Development Goal 3, create new jobs that have strengthened local and national economies and offered new opportunities to young people.
The new initiative is aligned with the World Health Organization's Global Strategy on Human Resources for Health.

UNAIDS
The Joint United Nations Programme on HIV/AIDS (UNAIDS) had been leading and inspires the world to achieve its shared vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. By 2030 **END** the epidemic of AIDS, tuberculosis, malaria and neglected tropical diseases and **COMBAT** hepatitis, water-borne diseases and other communicable

SUMMARY

- Ending the AIDS epidemic in 2030 appears to be on track with concerted multi-sectoral effort.
- "Ideal ARVs" need to be deployed to all PLHIV and special populations.
- HIVDR poses a real threat to eliminating HIV as test and start is implemented.
- Point of Care tecgnologies for routine viral load monitoring will be key to monitoring all levels of ART in low and medium income countries (LMICs).