ACCESS TO HIV DIAGNOSTICS IN SUB-SAHARAN AFRICA

WHO MEETING WITH DIAGNOSTIC MANUFACTURERS AND STAKEHOLDERS GLOBAL FORECASTS OF DIAGNOSTIC DEMAND FOR 2014 - 2018

TAPIWANASHE KUJINGA
THE AFRICAN AIDS CONUNDRUM

- Sub-Saharan Africa remains the epicentre of the AIDS epidemic with around 70% of the global burden of disease.

- This situation is exacerbated by lack of resources and the lack of domestic capacity to adequately respond to the HIV crisis.

- Consequently, most of the resources, strategies and pharmaceutical products are provided from external sources.

- Because of the large population of people living with HIV in the sub-region, as well as the substantial untreated population, ending HIV globally will entail greater focus on Africa.
SOME HIV TREATMENT REALITIES

- Access to HIV treatment in sub-Saharan Africa at personal level is compromised by a variety of factors, which include distance to health centres, multiple concurrent and conflicting financial burdens.

- A significant proportion of the population is rural-based and access to health centres means walking long distances or travelling by public transport.

- At national level, challenges include shortage of skilled health care staff, inadequate diagnostic capacity, weak supply chain management systems, weak data management systems and concurrent disease burdens.
From 2009, a six-country project aimed at eliminating paediatric AIDS (CEPA) was rolled out.

The objective was to address policy and operational bottlenecks to paediatric AIDS treatment.

Some of the challenges noted with respect to diagnostics were long turnaround times for EID tests, results not reaching mothers or health centres, challenges with collecting samples for DBS and overwhelmed centralised laboratories.

CEPA was the first advocacy campaign to call for point-of-care diagnostics.
FINDINGS FROM 5-COUNTRY ART SURVEY

- From 2013, PATAM carried out a 5-country survey to assess the state of access to ART and HIV diagnostics, amongst other objectives.

- All the countries surveyed were still using CD4 for detecting baseline immunity as well as monitoring ART.

- Viral load machines were mostly in central locations and mainly for research purposes or for EID. However, many countries are now switching to viral load assays for routine monitoring purposes.

- Payment for diagnostic tests was a barrier, and some patients would go without the routine CD4 tests as a result.
The country has moved on to scale up its viral load capacity to accommodate the huge number of people on ART, which currently stands at more than 1 million.

However, challenges still remain with the huge sample volumes, transportation of samples, staffing levels and persistent stock out of ARVs and other essential medicines in health centres.

The country also suffers from inequitable distribution of services with urban centres being better served than remote rural settings.
COUNTRY REALITIES: ZIMBABWE

- Zimbabwe has a relatively high HIV prevalence rate at 13% of the adult population.
- It is the first country in Africa to mobilise domestic resources for the HIV response.
- For EID, there are two centralised laboratories which test DBS samples.
- An evaluation of the SAMBA near point-of-care lab tool yielded significant sensitivity and specificity results.
- The country is working on a viral load scale up plan which is intended to achieve >90% coverage by 2018.
Malawi has piloted some ambitious HIV-related programs including electronic patient monitoring systems and Option B+ for PMTCT.

This is despite its relative resource poor rating.

Malawi is now switching to viral load monitoring with CD4 assays being used to detect baseline immunity for ART initiation.

However, viral load capacity utilisation remains low due to logistical challenges.

The use of the CD4 assay will be phased out from 2016 as the country plans to move to universal ART (test and treat).
SOME RECOMMENDATIONS: HIV TESTING

- HIV testing is widely available in health centres and dedicated HIV testing points.
- Most of the rapid HIV tests are free and available on demand.
- Many health centres now offer HIV testing on an opt-out basis, but in many antenatal centres, HIV testing is routine.
- There is need to ensure that HIV tests have better specificity and sensitivity to lessen the chances of false positive and false negative.
- A few samples are sent for ELISA quality control from every batch, and this does not allow for all false results for be verified.
- Need to focus at non-invasive testing methods.
The use of CD4 is likely to be phased out after the 2015 guidelines. Civil society anticipates that the new guidelines will adopt the test and treat approach in line with the 90/90/90 strategy.

There is need to scale up the production of VL lab tools to meet the anticipated increase in demand.

There is also need to reduce the cost per test to allow for affordability.

To address the challenge of patients not getting results, there is need to ensure that machines are equipped with capacity for automated results dissemination to the health centre and patient.

Lab tools should have multi-analyte capacity.
Some recommendations: POCT

- Point-of-care technologies have gone a long way in addressing the challenge of turnaround time for results experienced in remote settings.

- To adequately address the challenge, it is suggested that POCT be:
  - Small and portable
  - Robust and durable
    - Able to run on alternative power such as solar or battery
  - Easy to operate – should not need a lab technician
  - Short turn around time <2 hours
  - High sensitivity and specificity
THE ROLE OF CIVIL SOCIETY

- Civil society has been advocating for access to treatment for HIV and opportunistic infections since the advent of the pandemic.

- With the massive ART rollout, focus has turned more to quality of ART regimens including safety and efficacy, quality of treatment, monitoring ART scale up etc.

- Diagnostics came into the civil society focus a bit late, but with the new drive towards elimination of AIDS, this is changing.

- Civil society can hold governments and other stakeholders accountable, can monitor developments at community and service recipient level and can create demand for products and services.

- Can also follow up on people on treatment or in need of treatment at community level.
SOME ISSUES FOR ADVOCACY ON DIAGNOSTICS

- Scaling up diagnostic capacity at all levels – national, provincial, district, local.
- Equitable distribution of lab tools, i.e. put more focus on rural areas.
- Efficient capacity utilisation of diagnostic tools.
- Increasing skilled human resources for health to process samples and esp to increase efficiency in sample collection.
- Roll out efficient electronic data management systems to monitor people tested for HIV, on ART, on particular regimens and other essential data.
- Improve on supply chain management systems, including cold chain.
THANK YOU