2019

STRATEGIC FRAMEWORK FOR RESPONDING TO THE HIV EPIDEMIC: 2019-2023

STRATEGIC PAPER

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1. GAPS IN GLOBAL RESPONSE

The global response to HIV epidemic has resulted in a 18% decline in HIV incidence in the past 7 years; 21.7 million of 36.9 people living with HIV (PLHIV) are receiving antiretroviral treatment (ART) and for the first time the number of AIDS related deaths dropped below 1 million in 2017[1]. We have made significant steps forward, but we are only half way through a successful epidemic response: 25% of people living with HIV do not know their status and only 59% are on life saving treatment. Many people are still at high risk of opportunistic infections (OIs) and HIV related mortality.

In many countries supply systems are too weak to sustain uninterrupted treatment and the dwindling international funding is further threatening the supply of the commodities.

In July 2018 UNAIDS has warned that progress has been slowing down due to reduced overall political and financial commitment to the HIV response. If HIV fatigue continues, it will be difficult to progress or even to sustain previous achievements[1]. Any reported success in the HIV epidemic has to be balanced against the remaining gaps and emerging challenges:

1.1 REGIONS AND CONTEXTS LEFT BEHIND

Provision of HIV care in complex humanitarian emergencies remains one of the major gaps in the HIV epidemic response. Humanitarian emergencies and armed conflicts, especially those with prolonged character, increase vulnerability and inequity among the affected populations, including risk of HIV transmission and access to HIV care services. Data on gaps in HIV care from such context are scarce, but it has been reported that out of 1.6 mil PLHIV affected by a humanitarian emergency in 2013, 1.29 mil could not access lifesaving treatment[2].

Due to political instability and lack of domestic or international commitment, reduced financial resources, underdeveloped health systems and competing health priorities West and Central Africa (WCA) region, with 6.1 mil PLHIV, remains lagging behind, contributing to 30% of all HIV related deaths; only 26% of children and 41% of adults received ART in Western and Central Africa in 2017. Nigeria carries more than half of the HIV burden in the region and showed little progress over the last years. In the last 20 years the annual number of new infections has doubled in Eastern Europe/Central Asia and increased by a quarter in the Middle East/North Africa. The epidemic is on the rise, particularly among populations at high risk[3], while only a third of people living with HIV access ART in those regions.

[1] UNAIDS Global AIDS Update 2018, Available at: http://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf
[2] HIV in Humanitarian Emergency, UNAIDS, 2015 (Available at: http://www.unaids.org/en/resources/presscentre/featurestories/2015/march/20150304_humanitarianemergencies)
[3] Commercial sex workers and their clients, men having sex with men, people who inject drugs (Source: UNAIDS Global AIDS Update 2018, Available at: http://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf)

1.2 ADVANCED HIV DISEASE/AIDS

In resource limited settings 40% of PLHIV enter or re-enter HIV care with advanced HIV disease/AIDS[4]. Tuberculosis and cryptococcal meningitis remain the leading causes of death and implementation of the WHO guideline[3] on the package of care for advanced HIV disease remains very slow, with almost no capacity to manage advanced HIV disease at primary and secondary care level in the majority of settings where MSF works. Current models of care are insufficiently adapted to support long-term retention in care and adherence, not taking into account the reality that patients cycle in and out of care and increasingly present with treatment failure and drug resistance.

1.3 NEGLECTED POPULATIONS: UNTESTED-UNTREATED-UNSUPPRESSED

1.3.1 Key populations

47% of the global and 97% of all new infections in Eastern Europe and Central Asia are among key populations and their sexual partners: men who have sex with men, sex workers, transgender people, and prisoners[5]. Dedicated responses, tailored to the specific medical needs of these groups are globally recommended, but rarely implemented. Key populations are at the highest risk of HIV infection and suffer from high burden of co-morbidities (TB, HCV). Yet, due to criminalizing laws, stigma and social marginalization those populations are the most excluded from access to health care, including HIV prevention, diagnosis and treatment. Where there is a minimal response to their needs it is often dependent on external funding and as international funding declines, particularly in 'middle-income countries' the future response is compromised.

1.3.2 Children and young people

Only half of children had access to ART in 2017 and HIV infections among new-borns are still occurring at high rates (180,000 in 2017)[6]. Children infected vertically are at higher risk of HIVDR (42.7% of those who fail PMTCT will have resistance to NNRTI based first line). Despite WHO recommendations to provide PI based first line to children, up to 80% globally will remain on regimens with high risk of failure[7]. Access to and existence of paediatric formulations remain key main challenges addressed by very few actors besides MSF.

Young people (10-24), especially young women and young key populations, are disproportionally affected by HIV. The number of adolescents living with HIV has risen by 30% between 2005 and 2016[6]. The HIV response for young people remains challenging due to reduced access to HIV services, age restricted laws for access to SRH services, need for parental consent to access HIV care, unfriendliness of clinics/staff, stigma, insufficient HIV testing and overall neglect of adolescent care in general. Retention in care and adherence to treatment are particularly challenging and targeted approaches to this age group remain a gap in many of the settings.

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[4] WHO. Guidelines for managing advanced HIV disease and for rapid initiation of antiretroviral therapy, 2017 (Available from: http://apps.who.int/iris/bitstream/handle/10665/255884/9789241550062-eng.pdf;jsessionid=4EB537CF2E352DF9BC4E2B6CE871205A?sequence=1)

[5] UNAIDS Global AIDS Update 2018, Available at: http://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf

[6] UNAIDS Global AIDS Update 2018, Available at: http://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf

[7] Jordan R et al. Human Immunodeficiency Virus (HIV) Drug Resistance in African Infants and Young Children Newly Diagnosed With HIV: A Multicountry Analysis. *Clinical Infectious Diseases*, Volume 65, Issue 12, 29 November 2017, Pages 2018–2025.

1.3.3 Treatment failure and Emerging HIV Drug Resistance (HIVDR)

Access to routine HIV Viral Load (VL) is a challenge for many settings, as well as proper management of treatment failure and access to second (SL) and third line (TL) ART. Only a minority of patients failing treatment are identified and switched to an efficacious treatment regimen. Antiretrovirals with better efficacy and a higher genetic barrier (e.g. dolutegravir, DTG) are available, but strategies for their scale up are yet to be developed. HIVDR poses a new public health threat by contributing to increased HIV mortality, transmission and cost of HIV programmes. Children and adolescents, women and key populations are at the higher risk of HIVDR. The HIV funding crisis will significantly contribute to HIVDR problem, as uninterrupted continuation of care (stock outs) or access to good quality drugs in many programmes is a challenge and are foreseen to increase in the coming years[8,9] .

2. MSF PRIORITIES 2019-2023

In the following 4 years, MSF will prioritize:

1. RESPONDING TO NEGLECTED CONTEXTS

- Complex humanitarian emergencies
- Low coverage regions, particularly West and Central Africa

2. RESPONDING TO NEGLECTED POPULATIONS

- People living with advanced HIV/AIDS
- Children and young people living with HIV/AIDS
- Key populations
- People with treatment failure and/or HIV drug resistance

Our Approach

Combining our collective operational presence, engaging with communities and patients, fostering their autonomy and participation, MSF will provide direct clinical care, and will conduct focused operational research to innovate and advocate for change, linked with a patient-centered witnessing and a programmatic analysis of present and future threats to the overall and country-specific response.

This will require a critical mass of projects using targeted operational research and innovative strategies for prevention, diagnosis and treatment. We will use our data, evidence gained and voice to catalyze political and technical change and commitment at national, regional and global level.

At the same time, we will continue to monitor and advocate for continued funding support to existing programmes and new priorities, as the epidemic evolves.

[8] Gils et al. Stockouts of HIV commodities in public health facilities in Kinshasa: Barriers to end HIV. PLoS One. 2018 Jan 19;13(1):e0191294. doi: 10.1371/journal.pone.0191294. eCollection 2018.
[9] Ambia J et al. From policy to practice: exploring the implementation of antiretroviral therapy access and retention policies between 2013 and 2016 in six sub-Saharan African countries.. BMC Health Serv Res. 2017 Nov 21;17(1):758. doi: 10.1186/s12913-017-2678-1.

2.1.1 HIV response in complex humanitarian emergencies

Where relevant, MSF will aim to integrate HIV care in our emergency response. MSF will commit to innovate models of HIV care delivery in such complex settings, including HIV emergency preparedness, strategies for HIV testing, ART distribution and HIV VL monitoring, as well as contingency planning and community/peer engagement. MSF will aim to document experiences from our programmes and use those for joint advocacy efforts for the HIV care needs in humanitarian emergency and opportunities for HIV care delivery. Improved M&E tools should be emphasized, as the good data are basic for successful advocacy.

2.1.2 HIV response in low coverage regions

MSF will continue its efforts to catalyse access to HIV care in settings with low coverage, particularly West and Central Africa, where HIV often remains one of the main causes of death in adult population. Commitment to innovate on simplification of HIV care delivery and to invest in engagement with the MoH, particularly on capacity building as well as to support community empowerment are necessary for laying the base for long terms structural responses, which others can take over and balance with other medical priorities.

In such contexts MSF will seek to harness collective efforts to maximize overall impact, through development of country specific intersectional HIV strategies and piloting new models of intersectional HIV support. This should lead to improved programme support, improved supply, resource sharing, joint representation to the MoH, improved learning and documentation of experiences of a critical mass.

As we predict that such settings are going to be heavily affected by the current HIV funding crisis, MSF should consider ensuring alternative funding mechanisms such as transitional MSF funding for ARVs to avoid increased treatment gap or treatment interruption rates that will contribute to increased mortally and HIVDR in the future.

2.2 ADVANCED HIV DISEASE/AIDS

MSF will implement or strongly advocate/support for rolling out of the full package of care for advanced HIV disease/AIDS in MSF supported programmes. MSF will continue to innovate on improved prevention, diagnosis and treatment of advanced disease/AIDS in multiple settings (stable vs conflict, rural vs urban, ambulatory vs hospital based, settings with different OI prevalence, models for prevention, diagnosis and treatment of cervical cancer, etc), recognizing the need to adapt/develop models of care to better support long-term retention and adherence.

With the support of the Access Campaign we will continue to advocate for access to improved diagnostics and affordable and less toxic treatments for all patients. MSF will commit to gather necessary evidence to contribute to international guidelines development and policy changes in regard to improved management and prevention of advanced HIV disease. Advanced HIV disease/AIDS will remain one of the main HIV advocacy priorities for MSF.

2.3 NEGLECTED POPULATIONS: UNTESTED – UNTREATED -UNSUPPRESSED

2.3.1 Children and young population

MSF will demonstrate innovative models of prevention (access to PreP, PMTCT), diagnosis (early infant diagnosis, HIV self-testing, peer promoted testing), strategies for improved linkage to care and retention in care in all settings where we work. At the same time the integration of HIV care in nutritional activities will continue. MSF will develop specific HIV pediatric and/or adolescent programs in a number of settings. MSF will continue to address the lack of access to appropriate first, second and third line pediatric drugs formulations.

2.3.2 Key populations

In settings where MSF has already access to key populations MSF will develop, document and promote innovative preventive, diagnostic, treatment strategies (HIV self-testing, PreP, long lasting injectables, vaginal rings, innovative models of HIV care delivery for migrants and prisoners) as well as comprehensive package of care being delivered as one stop services. Communities will be promoted as active participants in the process of assessing the needs, design of model of care and care delivery for specific population groups.

In high burden areas where access to key populations remains limited, MSF will engage with the community groups and other stakeholders and will strive to develop innovative strategies to increase access and provide necessary medical care.

2.3.3 Management of treatment failure and HIV drug resistance

MSF will support global fight against emerging HIVDR and increasing numbers of patients failing ART. MSF's added value will be in its capacity to demonstrate and advocate for innovative strategies to improve the cascade: HIV DR prevention (sustainable drug supply, good quality drugs, adequate dosing and formulations, good patient adherence), improved detection of treatment failures (access to routine HIV VL, access to HIVDR testing) and improved management of treatment failures (early detection of HIVDR, early switch with decentralised access second and third line regimens, improved second and third line regimens). MSF will support role out of antiretrovirals with improved and patient friendly efficacy and higher genetic barrier (e.g. dolutegravir) for all patients, including children and pregnant women. At the same time, we will continue lobbying for affordable and improved second and third line regimens.

3. OPERATIONAL RESEARCH AGENDA AND ADVOCACY

In order to achieve the ambitions of this strategic framework MSF stays committed to a *catalytic* or "*change*" approach in order to improve the lives of patients beyond our projects. Strategies to achieve this include innovation, operational research and advocacy aiming to inform and influence national and international policies and guidelines that improve access and quality of HIV care for the populations left behind. MSF will support targeted advocacy and operational research that reflect operational HIV priorities described in this strategic framework.