ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

Review of the Democratic Republic of the Congo (DRC) by the Committee on the Elimination of Discrimination Against Women (CEDAW)

Submission: Elizabeth Glaser Pediatric AIDS Foundation

June 2013

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Introduction: EGPAF in the DRC

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) is a leading implementer of HIV/AIDS prevention, care, and treatment services in the Democratic Republic of the Congo (DRC).

EGPAF began supporting critical prevention services in the DRC in 2001, supporting prevention of mother-to-child transmission of HIV (PMTCT) programs implemented by the Kinshasa School of Public Health (KSPH) and the University of North Carolina (UNC). In subsequent years, EGPAF added support for care and treatment programs to its portfolio of work in the DRC, including male involvement, early infant diagnosis of HIV, and sexual and gender-based violence services. Today, EGPAF/DRC also supports syphilis testing and treatment; TB/HIV co-infection services; family planning services; and HIV treatment for clinically eligible HIV-positive pregnant women, their male partners and other family members.

EGPAF currently supports services in four of the country's eleven provinces, implementing activities in more than 140 sites.

HIV in the DRC

Over a decade of civil war, political instability, and violence in the Democratic Republic of Congo (DRC) has resulted in a weakened and overburdened health sector. HIV is now a generalized epidemic with more than 1.1 million Congolese infected as of the end of 2011.[1]

National HIV prevalence is approximately 1.6 percent; however, prevalence among adults aged 25-49 is estimated to be 4.2 percent, with infection rates as high as 9.5 percent in some areas.[2]

The 2007 the DRC Demographic Health Survey (DHS) estimated that only 9 percent of adults know their HIV status, in part due to the limited availability of HIV counseling and testing (HCT). Access to lifesaving HIV treatment and critical HIV prevention, care and support services is also limited. The National AIDS Control Program (PNLS) estimates that only 10 percent of eligible people living with HIV (PLHIV) are enrolled on antiretroviral therapy (ART) and less than 30 percent of those enrolled are receiving palliative care.[3]

The Ministry of Health (MoH) and PNLS have taken lead roles in addressing the HIV epidemic in the DRC. In recent years, the MoH has decentralized the health care system, placing increased responsibility on Health Zones (HZs). In 2012, the Government dedicated a portion of the national budget to HIV for the first time, but adequate financing for HIV remains elusive. At present, the DRC is completely dependent on donors for all anti-retroviral medication (ARVs). Basic inputs, such as health provider salaries, are grossly insufficient, resulting in frequent staff turnover and necessitating expensive re-training.

Fragmented and uncoordinated interventions amongst implementing partners and sites have led to ad-hoc HIV service provision, making it difficult for women living with HIV to access comprehensive HIV services. Women living with HIV in the DRC continue to face high levels of stigma in the community and by healthcare providers.

Care and support services for children and adults living with HIV are not widely available in the DRC.

[1] PEPFAR DRC Operational Report, PY 2011
[2] 2012 DRC National Elimination Plan for Pediatric HIV (PNLS)
[3] PEPFAR DRC Operational Report, PY 2011

There are **limited services for preventing mother-to-child transmission of HIV** (PMTCT) in the DRC, with only 11.3 percent of health facilities in the country offer PMTCT services. National PMTCT statistics indicate access to and uptake of PMTCT services are as low as 4 percent. There are significant challenges to **adherence and retention** in care for mother-baby pairs throughout the PMTCT period. One study found that only 43 percent of HIV-positive pregnant women in Kinshasa return to the site where they sought PMTCT services for their delivery, preferring instead to deliver at a facility where their HIV status was unknown, often due to fears of stigma.[4]

Reaching women in need of PMTCT services can be difficult since few women attend all four recommended antenatal care (ANC) visits, and many do not present for their first ANC until the third trimester.

Limited ANC attendance leads to reduced HIV testing and missed opportunities for HIV-positive pregnant women to begin ART for PMTCT and for their own health.

Selected PMTCT Statistics[5]		
Indicator	**DRC**	**Global**
HIV prevalence among pregnant women attending ANC	3.5%	*Not available*
Percent of HIV-positive women who received ART for PMTCT	4%	57%[6]
Percent of HIV-positive pregnant woman clinically eligible for ART for their own health with access to treatment	15%	30%[7]
Estimated rate of HIV transmission to exposed infants	37%	20%[8]
Percent of HIV-positive women who received early infant diagnosis of HIV within the first 2 months of life	1%	28%[9]

Sexual and gender-based violence in the DRC

Sexual and gender-based violence (SGBV) is one of the greatest threats to women's health in the DRC, where SGBV rates are among the highest in the world. Power inequality, and physical and sexual partner violence have been linked to a substantial proportion of new HIV infections in the country, yet the issue is not being adequately addressed. Laws regarding SGBV exist but are relatively unknown among the general population and are rarely enforced.

Government response

In its *Combined sixth and seventh periodic report* to CEDAW, and its *Replies to the List of issues and questions with regard to the consideration of periodic reports,* the DRC government noted that it has

[4] Evaluation of ANC and Deliveries at the Health Zone Level in Kinshasa (EADHK), funded by EGPAF
[5] DRC statistic are from the 2012 DRC National Elimination Plan for Pediatric HIV
[6] UNAIDS Report on the Global AIDS Epidemic, 2012
[7] Global Plan Towards The Elimination Of New HIV Infections Among Children By 2015 And Keeping Their Mothers Alive, Report of the midterm review meeting, Nairobi, Kenya, 6-7 December 2012
[8] UNAIDS, A progress report on the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive, 2012
[9] UNAIDS, Towards Universal Access, 2011

established a national multi-sector plan on HIV/AIDS (PNMLS), a National Policy on Gender Issues (PNG), and an Act on Sexual Violence, that it has adopted a strategy for prevention of mother-to-child transmission of HIV, and also that provisions are being made for provider-initiated HIV testing and counseling (PITC) for all pregnant women and ARV therapy for all pregnant women living with HIV. Where available, PITC has been extremely successful with extremely high acceptance of HIV testing amongst pregnant women. Unfortunately, despite these policy advances, resources remain scarce, and the DRC remains nearly 100% donor dependent for all HIV services and commodities. To ensure success, the international community needs to support the government of the DRC in accessing a reliable sources or ARVs, and the government needs to invest in basic health infrastructure including provider salaries. In addition, due to the DRC's large population and low number of trained providers, a policy shift that allows task shifting of ART initiation to nurses would allow HIV services to reach a broader population.

Recommendations:

- **Increase access** to quality comprehensive HIV/AIDS prevention, care, and treatment services and **address barriers to women** accessing such services.

- **Increase national financing** for HIV prevention, care and treatment services, with a view to becoming less dependent on donor aid and in line with commitments made under the Abuja Declaration, in which African governments pledged to allocate at least 15 percent of their annual budget to improve their health sector.

- **Ensure that all women receive voluntary testing for HIV during ANC visits or facility deliveries,** as the DRC's high fertility rate (six live births per woman),[10] and high rates of at least one ANC visit per pregnancy (87 percent)[11] make PMTCT the perfect entry point for identifying HIV-positive women and linking them and any HIV-positive partners and children into care and treatment services for HIV.

- **Strengthen integrated clinical services through implementation of a multi-pronged, coordinated approach at national, provincial and zonal- levels.** Integrated services will strengthen the national health care system and create efficiencies by reducing redundancies and programmatic costs, while also streamlining patient flow and reducing barriers to adherence and retention in services.

- **Ensure that a minimum package of integrated HIV services is offered in each Health Zone.** To do this effectively, the DRC government should conduct methodical reviews of needs and gaps and adapt tools, successfully developed and tested in other African countries, to ensure all HZs meet benchmarks for the provision of integrated HIV services. The DRC government should also provide support to HZs to assess, plan, and monitor site performance to ensure a minimum standard of quality services are available to clients.

- **Encourage the establishment of peer support groups to improve women's adherence and retention in PMTCT and HIV services.** To mitigate stigma and discrimination, peer support groups specifically designed to provide psychosocial support to HIV-positive women should be established. Psychosocial support empowers women living with HIV to take better care of themselves, disclose their status to family and friends, speak out in the community, and

[10] 2007 DRC Demographic Health Survey Report
[11] Ibid.

support friends. Support groups also play a key role in tracing and encouraging attendance at health facility appointments.

- **Build the capacity of Health Zones to ensure access, quality and sustainability in all aspects of health service delivery planning, management, and monitoring.** The technical and management capacity of zonal teams needs to be built to expand service delivery at the primary, secondary and tertiary levels. The government should support health zones to assume increasing levels of responsibility for planning, implementing, managing, and sustaining delivery of high-quality, integrated and comprehensive HIV services.

- **Update monitoring and evaluation (M&E) systems for PMTCT, HIV care and support, HIV/TB integration, and HIV treatment,** ensuring that updated M&E system and tools are rolled-out to sites, health zones, and provincial units.

- **Establish tracking systems** to follow mother-baby pairs from pregnancy through the breastfeeding period to ensure prevention of mother-to-child transmission of HIV to strengthen linkages between PMTCT and other HIV-services for the mother and her infant.

- Reinforce systems for **early infant diagnosis**, and organize integrated services and/or linkages to family planning; young child HIV care, support and treatment; and TB services.

- Ensure clinic-based HIV services and community-based support services assess and address the **reproductive health and family planning needs of women living with HIV,** such as promoting partner testing, disclosure, STI management, risk reduction and prevention counseling, and access to condoms.

- **Facilitate task-shifting** at at HZ and site levels, as this is an important element in rolling-out ARV treatment in the DRC, given the critically low proportion of doctors to patients.

- **Expand coverage of HIV services in TB Screening and Treatment Centers (CSDTs).** Integration of HIV and TB services in the DRC has been hindered by low service availability and a lack of integration between the respective national programs. Co-infection rates between TB and HIV patients indicate that investing attention in this area will help to identify and treat people at high-risk of HIV and TB co-infection. The government should ensure the availability of rapid HIV test kits, which will allow patients to be enrolled early in HIV care services so they can benefit from early co-infection case management. Every patient attending a TB consultation should also receive routine education and information about HIV.