INTERRUPTED HIV TREATMENT IN A FORGOTTEN CONFLICT

The Central African Republic

Situation
The recent escalation of conflict in the Central African Republic (CAR) is the latest in a serious of crises that have affected the country since the mid-nineties. Fighting between Séléka, an alliance of rebel forces and the Central African Army culminated in overthrowing the former government in March 2013 resulting in insecurity, violence, looting and robberies. Tens of thousands of people fled into the bush or were further displaced. Several hospitals and health posts were looted and numerous abandoned. Due to displacement and the non-functioning of health services many people living with HIV (PLHIV) on life-saving antiretroviral therapy (ART) were left without access to antiretroviral drugs (ARVs). Before the crisis, up to 15,000 PLHIV were on ART and roughly another 50,000 PLHIV eligible could not be covered. The number of lost patients on ART is estimated to be in the thousands by the Comité nationale de lutte contre le SIDA (CNLS).

A well-coordinated response of the humanitarian and health actors is underway to retrace lost patients on ART and to ensure the provision of the minimum package for HIV as lined out by the IASC Guidelines in the current emergency context.

The Challenge in Addressing HIV
The challenges to address the minimum services in the current crisis are multi-fold:
1. Insecurity and lack of infrastructure are persistent problems that create irregular access to large parts of the country. The resumption of conflict and the presence of different armed groups have rendered many zones inaccessible, impeding effective responses. Only few agencies are currently operating outside the capital. In addition, this is further hampered by a high turnover of international staff and many vacancies in humanitarian programs.

2. The health system is marginalised. Shortages of ARVs are widespread at present as supply chains and reporting lines are interrupted. In addition, in many places the qualified health staff fled or relocated to the capital. Some health facilities are left without any medical personnel.

3. Sexual and gender-based violence (SGBV) is rampant due to the frequent armed conflicts and violence that the country has experienced in recent years. The health system is insufficiently engaged to respond to SGBV and the clinical management of rape survivors including a limited availability of post-exposure prophylaxis (PEP) to prevent unwanted pregnancy, STI and HIV, limited counselling and psychosocial support. Furthermore, HIV transmission through blood transfusions and occupational hazards persists as well and is further aggravated by the crisis.

4. HIV related stigma and discrimination continue to prevent people from getting tested, from adhering to medication or from bringing their partners for testing. At the same time the epidemic is ageing and we see more people with advanced disease. A low level of knowledge and awareness about HIV persists. Only 17% of female and 26% of male young adults in the age of 15-25 years have comprehensive knowledge of HIV.

5. Sexual practices put adolescents and adults at risk of infection; multiple partners and low condom use are common factors increasing the risk of transmission. Inadequate livelihood opportunities force women and girls to risky behaviours such as exploitative transactional sex.
Urgent Action Required

The IATT on HIV in emergencies calls on humanitarian partners and donors, national authorities and other actors for rapid action to secure the Minimum services for HIV in emergency settings as lined out by the IASC. Key steps that should be taken in the short and medium term include:

1. **Enable safe and unhindered access to health care** and humanitarian assistance by the civilian population, including the security of humanitarian workers and assets.

2. **Restore security and rule of law** in order to enable civilians to resume their daily lives. This includes refraining from any actions that would prevent freedom of movement or provoke further forced displacement, and preventing destruction, looting of private houses and public buildings.

3. **Re-establish and strengthen national coordination mechanisms for HIV** with a focus on the requirements of the emergency situation. Better collaboration is needed among the governmental organisations, UN agencies and NGOs to secure the minimum essential services for HIV effectively, countrywide and in a rapid manner.

4. **Re-integrate HIV** as a crosscutting issue in the response activities to the current emergency of all clusters.

5. **Redeploy health personnel** to the abandoned health facilities and restart health services plus the minimum services for HIV including ART where it was provided before the conflict.

6. **Restore the distribution of ARVs**, lab consumables, and tuberculosis medicines and the availability of male and female condoms throughout the country.

7. **Actively start tracing back patients on ART lost in locations**, where they had fled into the bush and provide them with longer-term rations of ARV drugs for contingency, if needed. Scale-up the treatment in an expanded phase.


9. **Restore and scale-up the prevention of mother-to-child trans-mission (PMTCT)** while providing ARV drugs for pregnant women and lactating mothers as well as treatment, care and support for infants.

10. In a longer term **provide funds to strengthen the capacity of the health system**, to expand HIV services, train health personnel in providing HIV services such as PMTCT, safe blood transfusions, standard precautions and post-exposure prophylaxis including the clinical management of rape survivors. Strengthen community based organisations and PLHIV networks in the response against HIV. Ensure contingency plans for HIV during emergencies are in place for the future.

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1. Inter-Agency Standing Committee, Guidelines for HIV/AIDS interventions in emergency settings, IASC August 2010
2. Centre Nationale de Lutte contre le SIDA, Cadre stratégique Nationale de lutte contre le VIH et le SIDA 2012-2016, June 2012