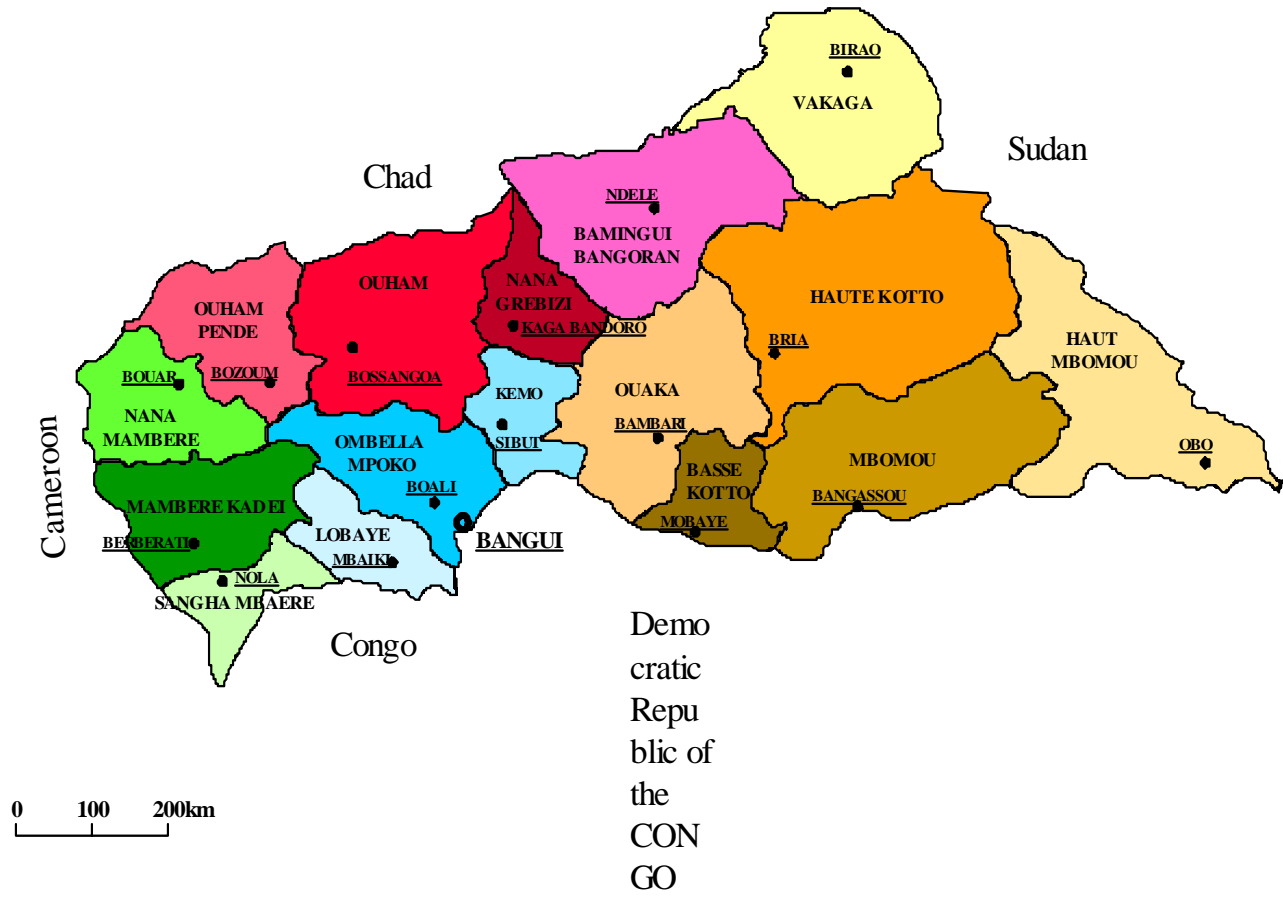


CENTRAL AFRICAN REPUBLIC

UNGASS Report 2003-2005



Central African Republic: UNGASS Report 2003-2005

TABLE OF CONTENTS

I. Status at a glance.....	3
II. Overview of the AIDS epidemic.....	4
III. National response to the AIDS epidemic.....	6
IV. Major challenges and actions necessary to achieve the UNGASS goals/targets.....	7
V. Support required from country's development partners.....	8
VI. Monitoring and evaluation environment.....	9
Appendices.....	
Appendix 1: Consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS.....	
Appendix 2: National Composite Policy Questionnaire (through CRIS).....	
Appendix 3: National Return Forms for the programme, knowledge, behaviour and impact indicators (through CRIS)	

Central African Republic: UNGASS Report 2003-2005

Name of country: CENTRAL AFRICAN REPUBLIC

I- Status at a glance

	Global report ONUSIDA (2005)	Country estimate 2003
Adult (15-49)/Prevalence rate of HIV	13.5%	14.8% ¹
Adults (15-49)/ Persons living with HIV	240,000	D.U
Young people (15 – 24)/ living with HIV	D.U ²	D.U
Women (15-49) living with HIV	130,000	D.U

Key programme data

Number of male condoms distributed by the Government by way of public health properties in 2005 (estimate)	416,800 of which 280,000 by the family health service and 136,800 by the social marketing programme (PMS) NB: 3,918,240 condoms were distributed by PMS on 30 September 2005
Number of persons who had access to CDV services in 2005 <ul style="list-style-type: none"> ▪ Men 6,150 ▪ Women 7,285 	13,435 persons screened (data from 9 CDVs) (16,153 of the total of persons came to the CDVs for screening and IEC)
Number of pregnant women who had access to the services of PTME (estimate)	3,950 (in the first 5 months of 2005)
Number of patients awaiting treatment at the end of 2005 <ul style="list-style-type: none"> ▪ Men 2,252 ▪ Women 4,504 	6,756 (seen by consultation, whereas estimated need is 18,253)
Number of persons receiving treatment at the end of 2005 <ul style="list-style-type: none"> ▪ Men 699 ▪ Women 1,048 	1,747
Number of deaths (adults and children)	131 adult deaths receiving ARV treatment (national data) 23,000 (ONUSIDA Report 2004)

¹ Median prevalence observed in pregnant women in 2002 (data from infection mapping);

² **DU** = Data Unavailable;

Central African Republic: UNGASS Report 2003-2005

Key demographic data (UNDP Report on Human Development)

Total population:	3,895,139 (RGPH Report 2003)
Age structure (in percentage)	
Age sector 0-4:	(16.6%)
Age sector 5-14:	(26.7%)
Age sector 15-24:	(20.6%)
Age sector 25-60	(25.59%)
Age sector 60 years +	(4.2%)
Life expectancy at birth: (42.7 for the whole)	40.0 (men) 45.7 (women)

UNGASS major basic indicators obtained in the country

Total national funds committed by the government to HIV/AIDS programme	742,927 \$ US
Percentage of pregnant women infected by HIV who receive full antiviral treatment to reduce the risk of parent-to-child transmission	16.41%
Percentage of persons who have advanced HIV infection who receive antiretroviral combination therapy	4%
Percentage of young people aged from 15 to 24 who admit using a condom when having sexual intercourse with a non-marital, non-cohabiting partner	26.45%
Percentage of young women and men who have had sexual intercourse before the age of 15	
- All	9.75%
- Women	9.91
- Men	9.60

II. Overview of the AIDS epidemic

▪ Epidemiological trends: progress and current status of the 2002-2005 epidemic

In Central Africa the Central African Republic is the most affected by the pandemic, being in the front rank of the countries of Central Africa and the ninth country in the world according to the global report of **ONUSIDA** in 2003.

Central African Republic: UNGASS Report 2003-2005

A mapping of HIV infection produced in 2002 by the **ST/CNLS** with the support of the Pasteur Institute financed by the World Bank, has revealed the size of the epidemic of HIV in the Central African territory. The prevalence of HIV in pregnant women in Bangui, the capital, varied from 7% to 21% according to the district with a median prevalence of 15%. According to this study the provinces were as much, if not more, affected as Bangui, with prevalences spreading from 4% to 28% and median prevalences of 13% in the towns and 17% in rural areas.

To appreciate the epidemiological situation of the infection during the 2005 period, routine data from the **Voluntary Screening Councils (VSC)** were used by proxy, in the absence of surveillance data from guarded sites. The following table shows the HIV infection situation in the VSCs which were put in place with the support of the Global Funds of the AIDS, tuberculosis and malaria programmes.

Table 1: Prevalence in different **VSC** centres in 2005.

Bangui		Bouar		Bria		Bambari		Bossangoa		Mobaye		Bangassou	
Male.	Fem.	Male.	Fem.	Male.	Fem.	Male.	Fem.	Male.	Fem.	Male.	Fem.	Male.	Fem.
14.5%	28.7%	14.4%	27.7%	12%	24.6%	13.5%	17%	6%	16.4%	8.2%	9.1%	4%	13.1%
22.8%		20.8%		17.5%		15.5%		11.6%		8.6%		8.2%	

Source: *Global Funds Management Unit.*

The table below shows the prevalence of HIV infection in pregnant women.

Table 2: Prevalence of HIV infection in **IPTE** pregnant women in 2005

PTPE site	HC	HA	Castors	Bimbo	Bégoua	Ouangou	BR	BC	Guita	SCAD	SAFA	Kokoro	HP.BAR	SOS
Prevalence rate	24.54	5.11	7.86	10.43	10.38	32.45	15.75	11.05	8.78	7.07	3.23	3.84	30.76	11.76

Source: *IPTE report 1st half 2005*

The number of persons living with HIV/AIDS was estimated as 240,000, while 23,000 deaths were AIDS related and 110,000 children were orphaned because of AIDS. Today AIDS is one of the principal causes of mortality and morbidity in Central African adults.

The Central African Republic is therefore a country witnessing a general epidemic, as not only are all social strata affected, but the rural areas are affected also, if not more than urban areas with prevalences exceeding 20% in some rural areas.

- **The impact of HIV/AIDS**

The Central African population is already too economically weak and is now strongly affected by HIV/AIDS. According to projections produced by the **IDEA** International Institute and **PNUD** in 2003, the HIV/AIDS epidemic will affect the size, composition and the state of health of the population. The number of **PVVS**s should be increased from now to 2015 to reach between 379 and 603 thousand individuals. The consequences for the natural population growth will be translated into the loss of strength of the order of 990 to 1070 thousand inhabitants in 2015.

HIV/AIDS has an impact in the short, medium and long term on the whole population and all sectors of the economy. It reduces the human capital, which thus affects the country's businesses and institutions.

Central African Republic: UNGASS Report 2003-2005

According to data from the same enquiry (PNUD and IDEA 2003), AIDS has a negative impact on economic and domestic activities. These are translated into complete arrest of activities (54.3% of cases) or reduction (32.8 %), by reducing time spent at work (55.7 %), by a lowering of income (77.2%); by the sale of goods to confront the illness (60 %), and by increased spending on food (38.6%). The impact of AIDS also translates into the domestic arena by an increase in spending related to health (53 %) to the detriment of other spending areas, for example education where 34.3% of households have stated that their income became less and less devoted to spending on education.

The HIV/AIDS epidemic affects the working population more up to the point where no socio-professional group escapes its impact. Absenteeism and lowering of the productivity of employees, increase in the cost of supplementary hours paid to workers replacing their sick colleagues, hike in the costs of social benefits due to funerals and medical expenses as well as the cost of recruitment and training of employees before replacing those who have died, are equally impacts which affect the State Budget and the financial results of businesses.

In the context of the functioning of social structures such as hospitals and schools, the most direct impact of HIV/AIDS is concerned with the reduction in human capital in terms of its quality and quantity. By way of example, an enquiry carried out in 1996, shows a raised proportion of specific mortality among teachers (86%). This results in more than 70,000 children of 6 to 11 years old not being correctly schooled (UNICEF/PNUD, 1999). The enquiry carried out by PNUD and IDEA also shows that 30% of households reduced the number of children attending school to better manage the PVVIHs.

Finally, it is estimated that a fall in the work force linked to AIDS, on the PIB would be of the order of 2.1% to 3.5% in 2015.

▪ **Justification of the increase in the epidemic**

The principal mode of contamination with HIV in RCA is by the hetero-sexual route. The condition of extreme poverty of the population motivates the search for material goods. Ignorance, illiteracy, resistance to change in sexual behaviour and the still more increased frequency of Sexually Transmitted Diseases are as much factors which favour this transmission. Likewise, insufficient technical material and consumables in the care structures constitute situations which are susceptible to favouring the transmission of HIV via blood. Mother-to-child transmission of HIV is significant with regard to the raised prevalence of HIV infection in pregnant women.

III. National response to the AIDS epidemic

Since the national commitment was reinforced in 2003 by the availability of ST/CNLS, a coordinating structure, with permanent financial support of a weekly flow of funds to supply the counterpart of the State of the Multi-sector Project of the AIDS Programme, in spite of cash-flow problems. These counterpart funds enable the functioning of ST/CNLS and certain supervisory activities in the decentralization area and purchase of drugs and reagents for the service units to be supported.

Within the framework of implementing national programmes for the HIV/AIDS Programme, the Government has been able to mobilise 53,984,832 \$US among the development partners. This sum is divided up in the following way according to the different sectors of the programme: 61.29% of the amount goes to the responsibility of medical and psychological services, 0.05% to reinforcing capacity, 7.71% to prevention, 29.73% goes to the reduction of the impact (OEV's service); 1.20% to coordination

Central African Republic: UNGASS Report 2003-2005

and 0% to evaluation monitoring. It clearly appears from this observation that much remains to be done in the area of mobilisation of resources to respond efficaciously to the different needs in the matter of the HIV/AIDS Programme.

In spite of actions already taking place, the mobilised resources are still most inadequate to enable UNGASS to achieve its objectives, as witnessed by the routine data of the **CDVs** which show a prevalence of HIV infection which is still raised (Table 1). In the absence of an enquiry into behaviour on a national scale, it would be dangerous to talk about the impact of actions to promote awareness over two periods without having measurement the indicators. But, by considering 27.08%, the value of the **GE-12** indicator (percentage of young women and men aged 15-24 years who have sexual intercourse with a non-marital, non-cohabiting partner during the last 12 months), we can maintain that the different programmes have not yet produced a true change in the young population. In the context of safety in transfusions, thanks to the support of **OMS/OPEP**, we observe a significant proportion of units of blood tested (89.13) before transfusion. Unfortunately this intervention only covers the capital and one administrative area. As regards the programme of HIV mother-to-child transmission, the support of UNICEF and global funds enabled coverage of 16.41% of pregnant women to be achieved; this coverage, low as it is, must be improved. Turning now to infected persons in need of antiretroviral treatment, the country registers a coverage rate of 4.20%. An effort must be made to increase this, especially for patients in the interior of the country.

Lacking a national enquiry on different aspects of the programme, it is difficult to establish a cause and effect relationship by a logical programme of the national programmes in the context of the HIV/AIDS Programme over the period under consideration.

IV. Major challenges faced and actions necessary to achieve the goals/targets

The major challenge encountered to achieve the goals has been the environment of socio/politico/military troubles which have characterised the period under consideration. In fact very few partners have supported the Central African Republic in the setting up of these programmes. Moreover, the lack of recognition of the importance of this principal tool of measuring the efforts of countries in the matter of national response has contributed to the non-achievement of the goals. In fact, very few of national partners have familiarised themselves with the indicators retained (UNGASS). To be precise, the inadequacy of the resources mobilised, in spite of the efforts of the Government and certain partners in the development has constituted a major challenge. The most striking example is the value of the **GE-7** indicator (percentage of persons suffering from advanced HIV infection who receive triple antiretroviral therapy: 4.20%). The resources mobilised have not been adequate to satisfy the expressed needs. Out of around 40,000 persons who could benefit from ARV treatment, RCA has only been able to mobilise 25 million \$ US for medically treating 5,000 patients.

In the domain of prevention by sexual routes, the major challenges to the achievement of objectives are, among others, the inaccessibility of RCA to **MAP** credit which would have allowed the activities of **Communication for Change in Behaviour (CCB)** to have been achieved. We must similarly note an inadequacy of financial resources to enable the activities of social marketing of condoms over the whole territory to be expanded.

The available data only concerns a part of the country, consequently it does not allow us to measure the progress accomplished over the whole territory. Since the first demographic and health enquiry carried out in 1995, no similar enquiry has been carried out. Realization of this enquiry during the period under consideration would have allowed information to be revealed, disaggregated according to gender, age group and residential area.

Central African Republic: UNGASS Report 2003-2005

Besides, the financial resources are inadequate for the collection of necessary data for publication of the basic indicators. For example, the epidemiological survey of the second generation was unable to be carried out due to lack of resources.

The prevention programmes in the CAR did not take into account the part linked to the consumption of injecting drugs, similarly those aspects linked to male homosexuality.

V. Support required from country's development partners

To assist the country in achieving its goals, the following actions are envisaged:

- Accompany **ST/CNLS** in the development process and implementation of the national Strategy;
- Contribute to the development of a unique national plan of evaluation monitoring taking into account the epidemiological survey
- Support the efforts of **ST/CNLS** in the mobilization of material, financial and human resources;
- Mobilise enough resources to accelerate the access of at least 20,000 patients receiving ARV treatment;
- Participate in the consensus workshop on the UNGASS indicators;
- Participate in all monitoring meetings on the retained indicators.

VI. Monitoring and evaluation environment

No common national framework for evaluation monitoring resulting from a broad consensus yet exists. However, conforming to its mandate, monitoring of the implementation of the different programmes of the HIV/AIDS Programme has been assured by **ST/CNLS** through the evaluation monitoring section. However, this institution does not have the resources to finance the National Monitoring and Evaluation Plan.

However, a mechanism has been put in place thanks to the support of consultants from the World Bank, but it has not been carried out due to the absence of approval by the partners in the Programme. An administrator was designated in 2003 to engage in the full-time activities of monitoring and evaluation of the national programme. There is a Technical Support Group (working committee or group) composed of representatives of partners, the civil company, and persons living with HIV/AIDS, which meets irregularly to coordinate monitoring and evaluation activities, but unfortunately this structure is no longer functional.

The Monitoring and Evaluation Unit of **ST/CNLS** does not manage the centralised national database.

There is a functional information system for health at the national and decentralised level, called the **National Health Information System (SNIS)**.

An education information system does not yet exist.

The country has not managed to publish an annual evaluation report on HIV/AIDS to include the data of the HIV epidemiological survey.

Reinforcement of the monitoring of UNGASS indicators

To achieve the objectives of UNGASS, it is necessary to pursue advocacy for the mobilization of resources necessary for the implementation of programmes and production of evaluation studies. Reinforcement of the capacity of partners to monitor evaluation is indispensable to understand the indicators and methodology of collection and analysis of data. In particular, accent will have to be put on the importance of making available an integrated plan of monitoring evaluation which will enable the different studies to produce measurements of the efforts of the country in relation to the national response.

A focal point must be formally designed in the partner institutions to facilitate periodic meetings between different managers involved in the collection of data.

Finally, it is necessary to take into account the UNGASS indicators in monitoring the implementation of the National Strategy.