

Community Based HIV Counselling and Testing (CBCT) Programme Implementation: Results and Lesson learned of HCT uptake and linkage

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Contents

- Overview of CBCT implementation strategy
- Summary of some key CBCT results in Oct 2014-Sept 2015
- Lesson learned regarding uptake and linkage of community based HCT

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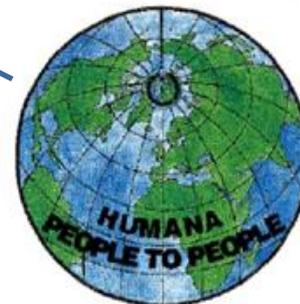
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CBCT Project Overview

Communities Forward -Comprehensive Community-based HIV Prevention, Counselling and Testing Program for Reduced HIV Incidence (Sector 3)

Prime Recipient

Sub Recipients

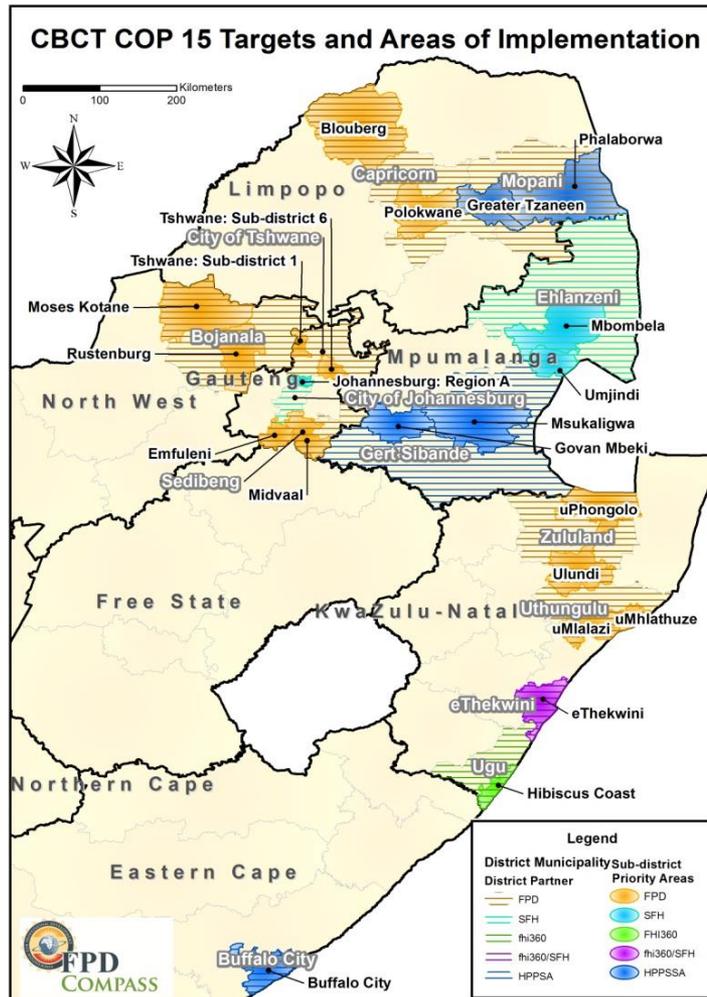


CBCT Goals

Goal

- to implement **high yield, community-based HIV counselling and testing (CBCT)** services with an aim to identify People Living with HIV (PLHIV) and to effectively link them into HIV and TB care and treatment programs
- to complement facility-based HIV Counselling and Testing (HCT) and reach HIV positive community members who may not access HCT services in the health facility setting.

CBCT geographic regions



Geographic allocation

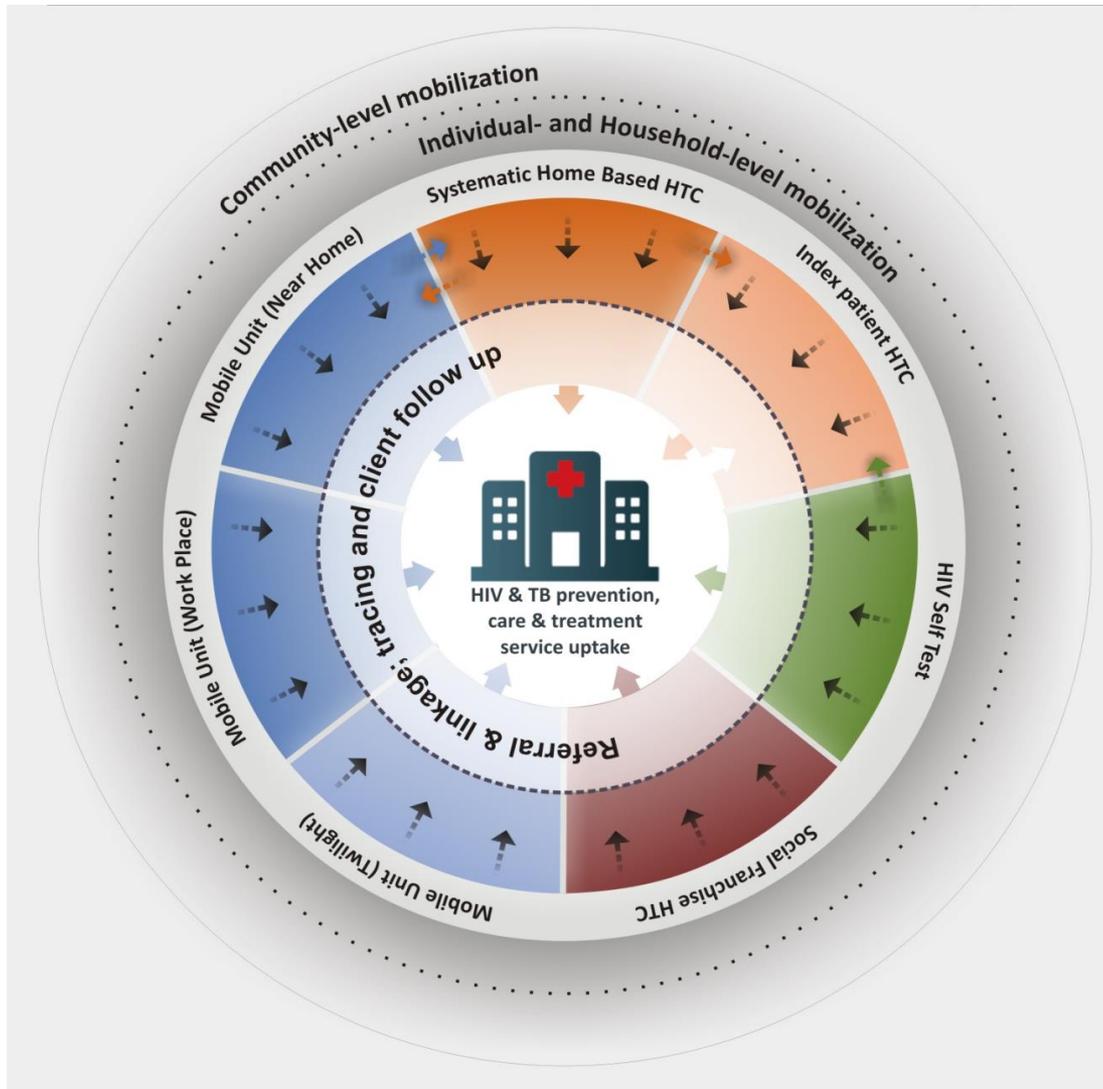
- Six provinces,
- 13 districts,
- 22 high burden sub-districts/local municipalities with focus on local micro-epidemics.

Target districts include:

- Buffalo City, Eastern Cape;
- City of Johannesburg, City of Tshwane, & Sedibeng, Gauteng;
- eThekweni, Ugu, uThungulu*, Zululand*, KwaZulu Natal;
- Capricorn & Mopani*, Limpopo;
- Ehlanzeni & Gert Sibande, Mpumalanga; and
- Bojanala, North West.

**CBCT just starting to implement*

Updated CBCT Combination Implementation approach layers 3 to 6 complementary, high yield HCT modalities



CBCT HCT modalities:

- systematic home-based HCT,
- index patient trailing home based HCT,
- mobile HCT
 - near-home,
 - workplace & First Things First
 - twilight

Demonstration projects

- HIV self testing (HIVST)
- HCT social franchise model

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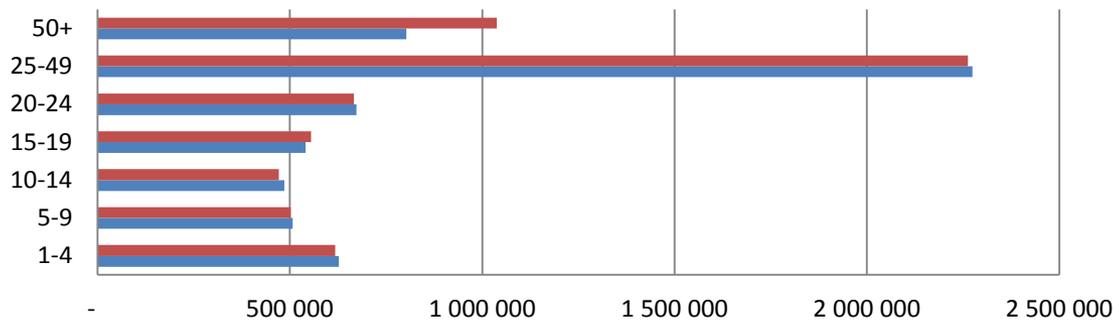


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CBCT has good uptake by priority pops: AGYW and men (Oct 2014-Sept 2015) (1/2)

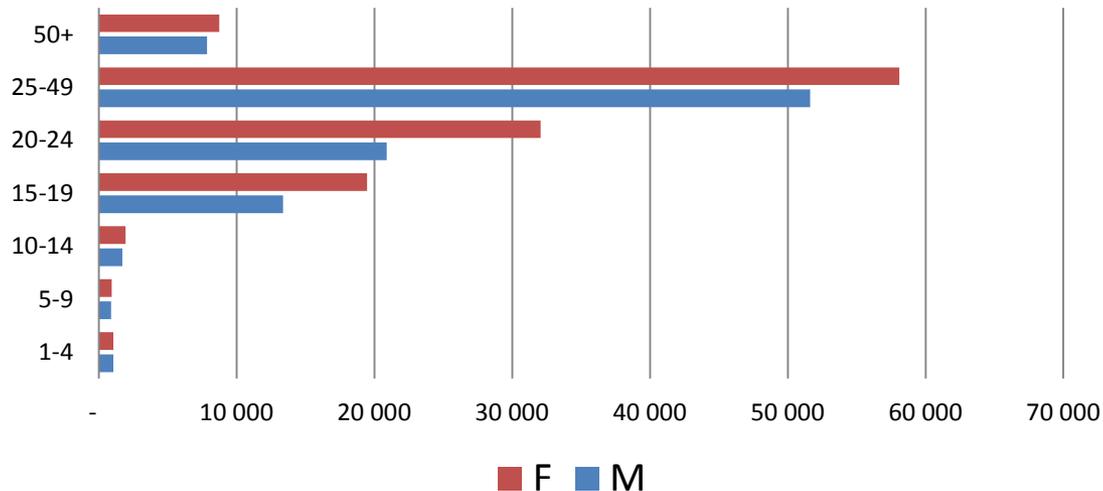
South African population pyramid (target districts combined)



CBCT HCT uptake rate per 10,000 population (combined pop of CBCT partnered sub-districts)

	M	F
1-4	16.95	17.01
5-9	17.47	18.61
10-14	35.20	41.03
15-19	247.04	350.59
20-24	310.20	480.89
25-49	226.94	256.81
50+	97.92	84.20

CBCT HCT uptake by sex and age group

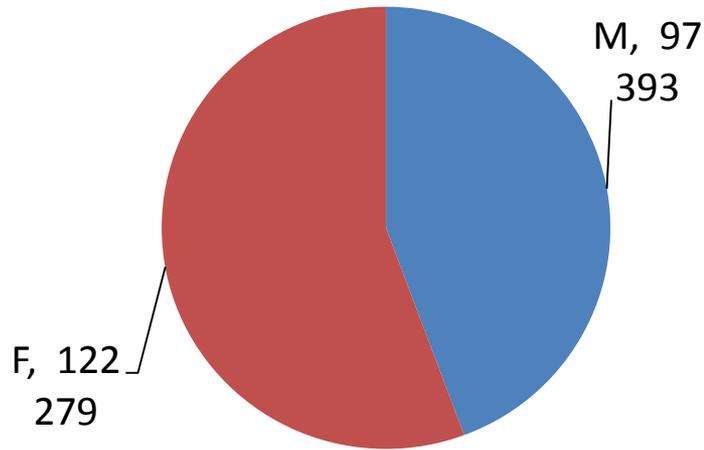


■ Priority population age groups

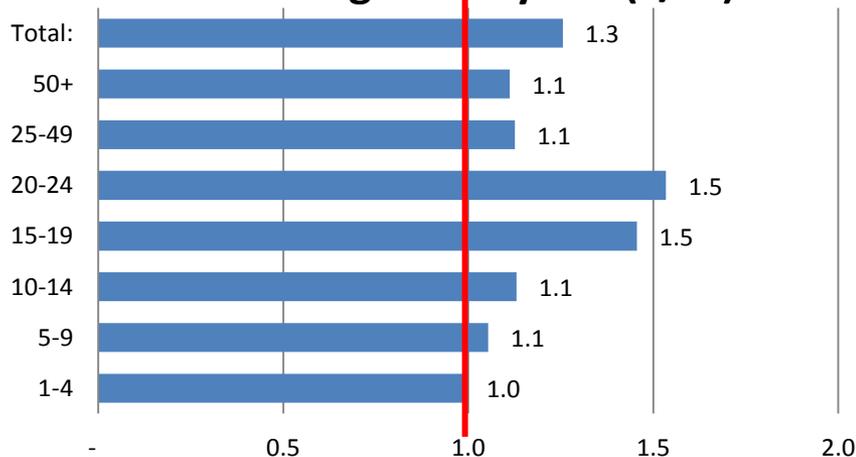


CBCT has good uptake by priority pops: AGYW and men (Oct 2014-Sept 2015) (2/2)

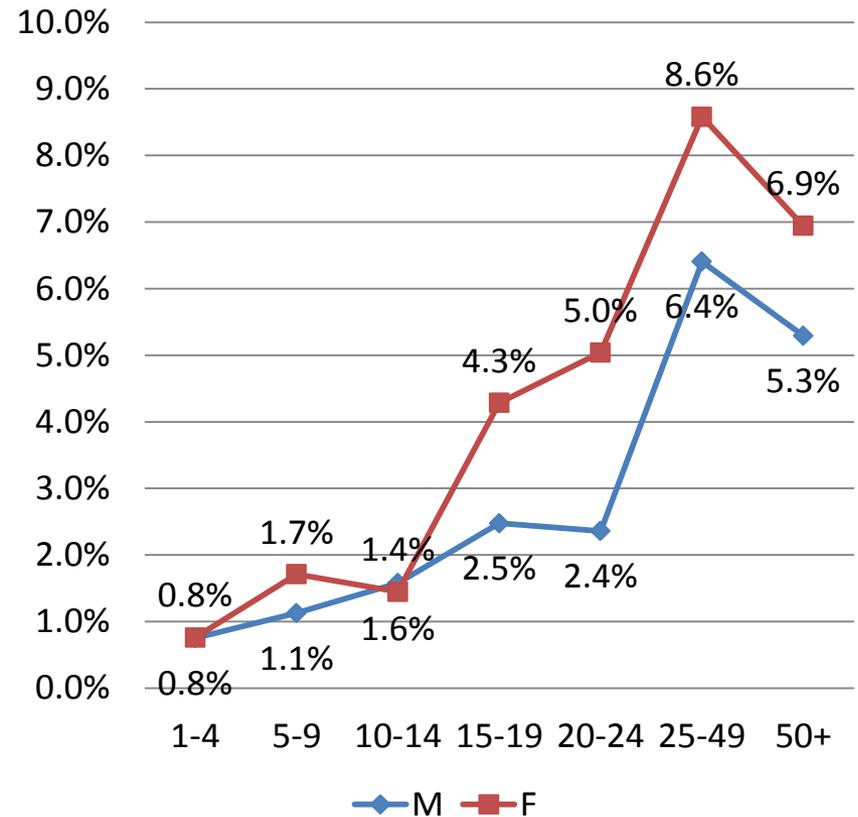
CBCT HCT uptake by sex



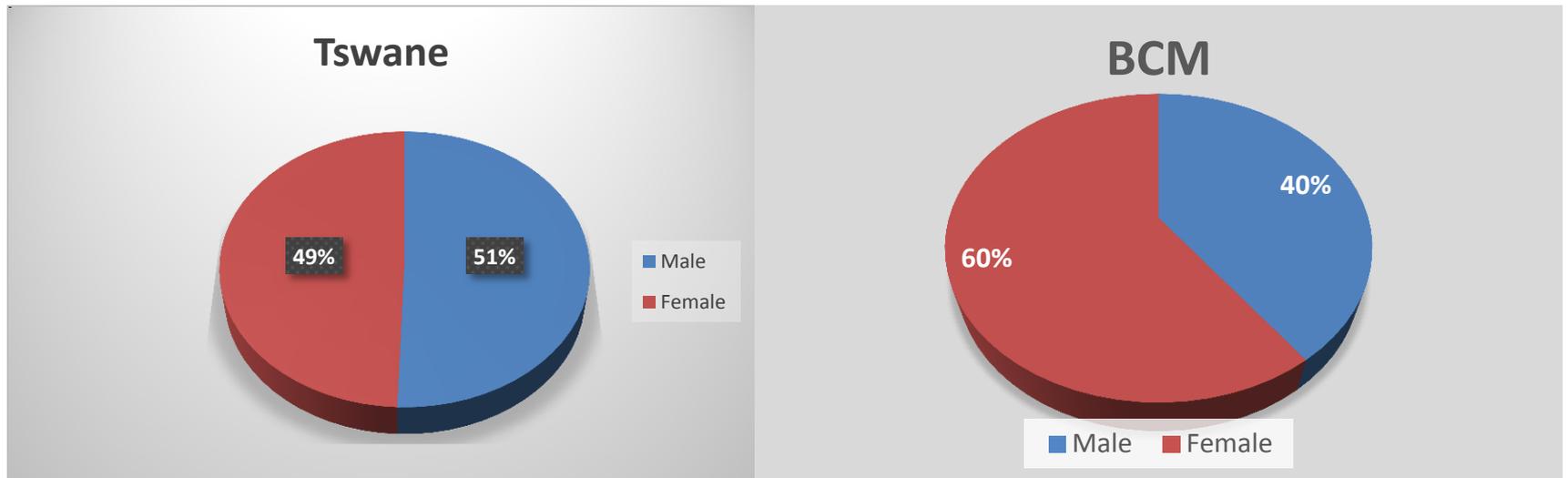
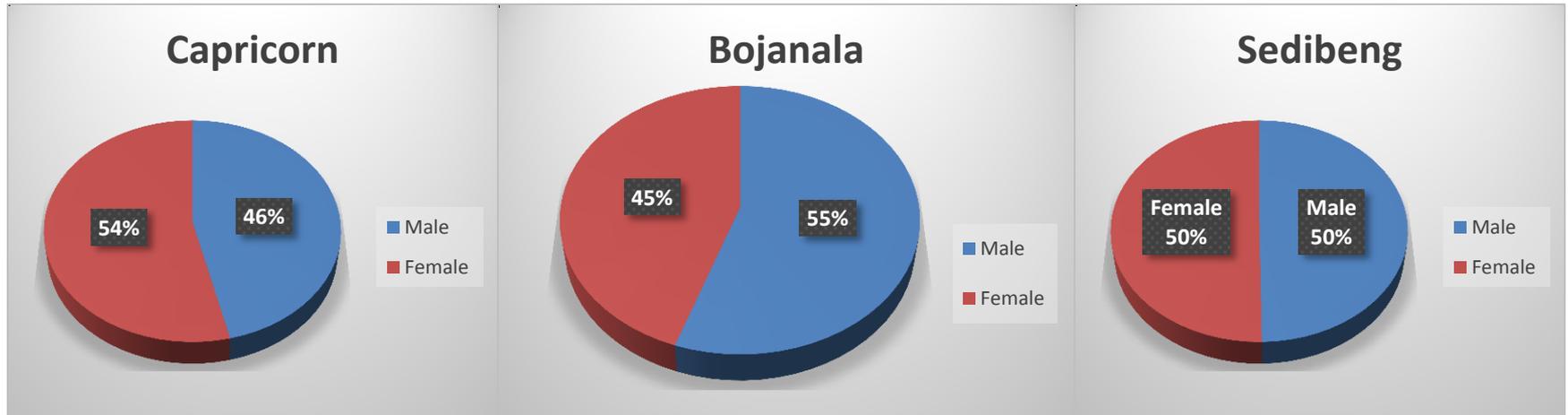
HIV testing ratio by sex (F/M)



HIV positivity rate by sex and age group

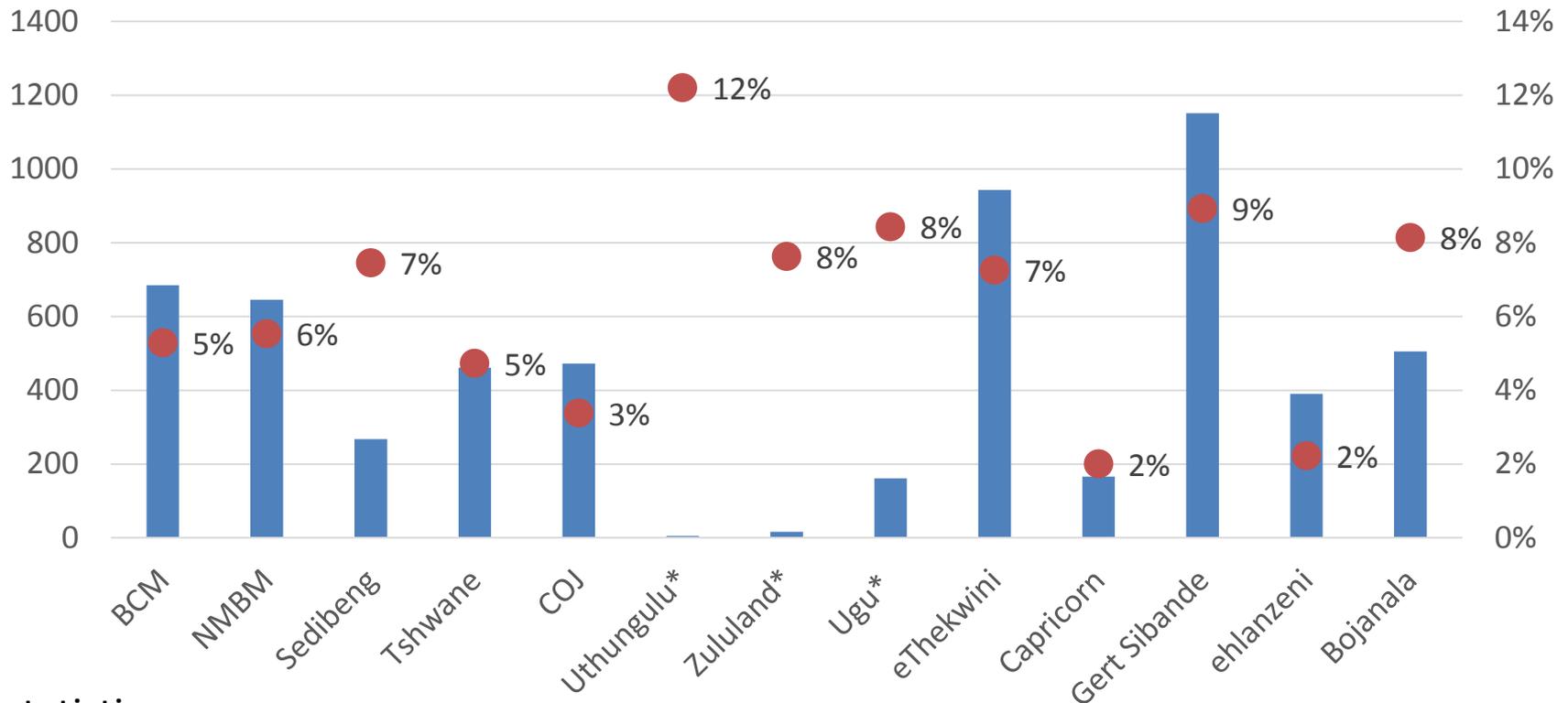


Sex distribution of CBCT clients per district



CBCT is seeing different yields depending on where and how we test (1/4)

HIV Yield and HIV positivity rate for CBCT in most recent quarter (July-Sept)



Q4 statistics:

HCT: 109,931

HIV Yield: 5,867

Positivity rate: 5.3%

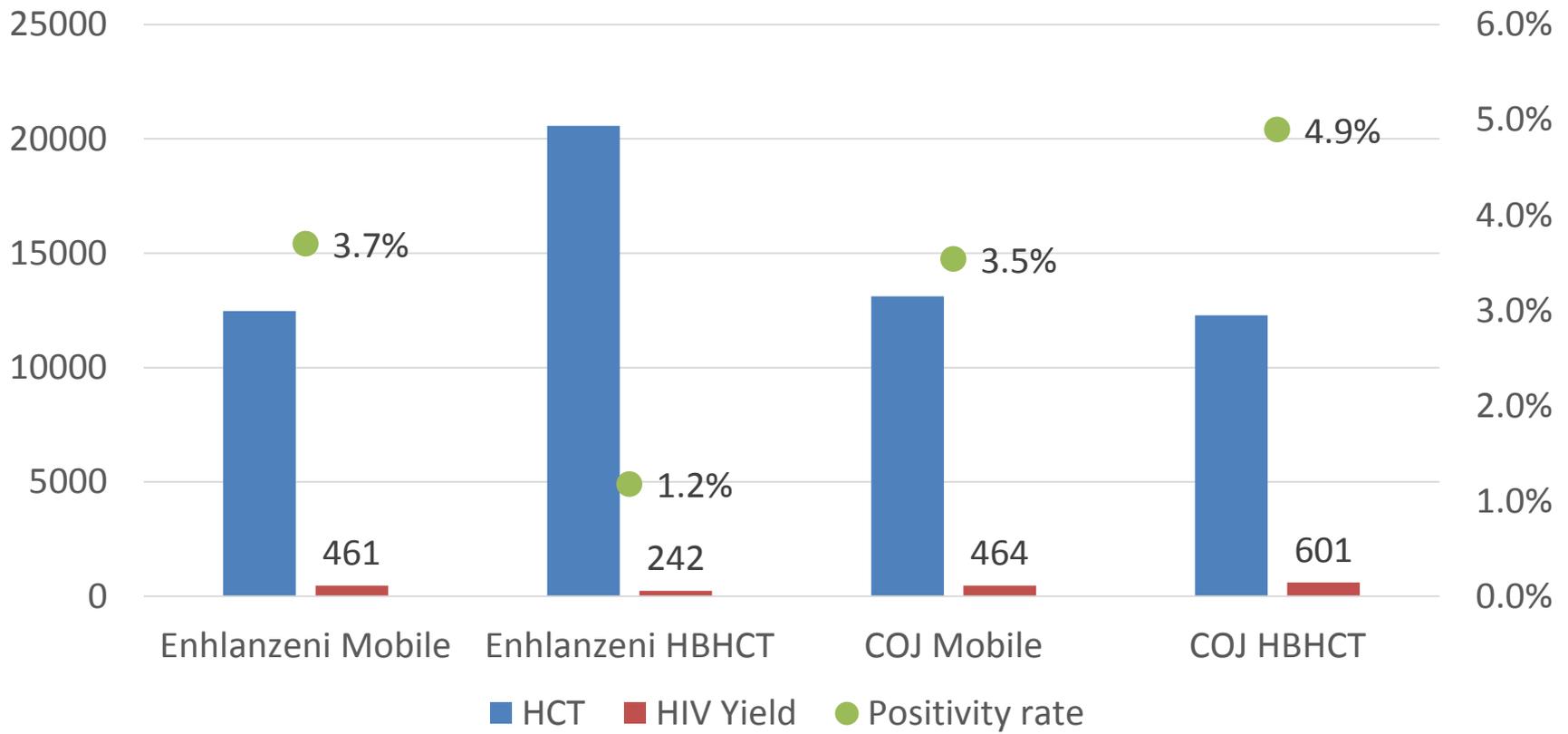
■ Q4 HIV Yield ● Q4 HIV Positivity rate

* Connotes a new district scaling up for CBCT



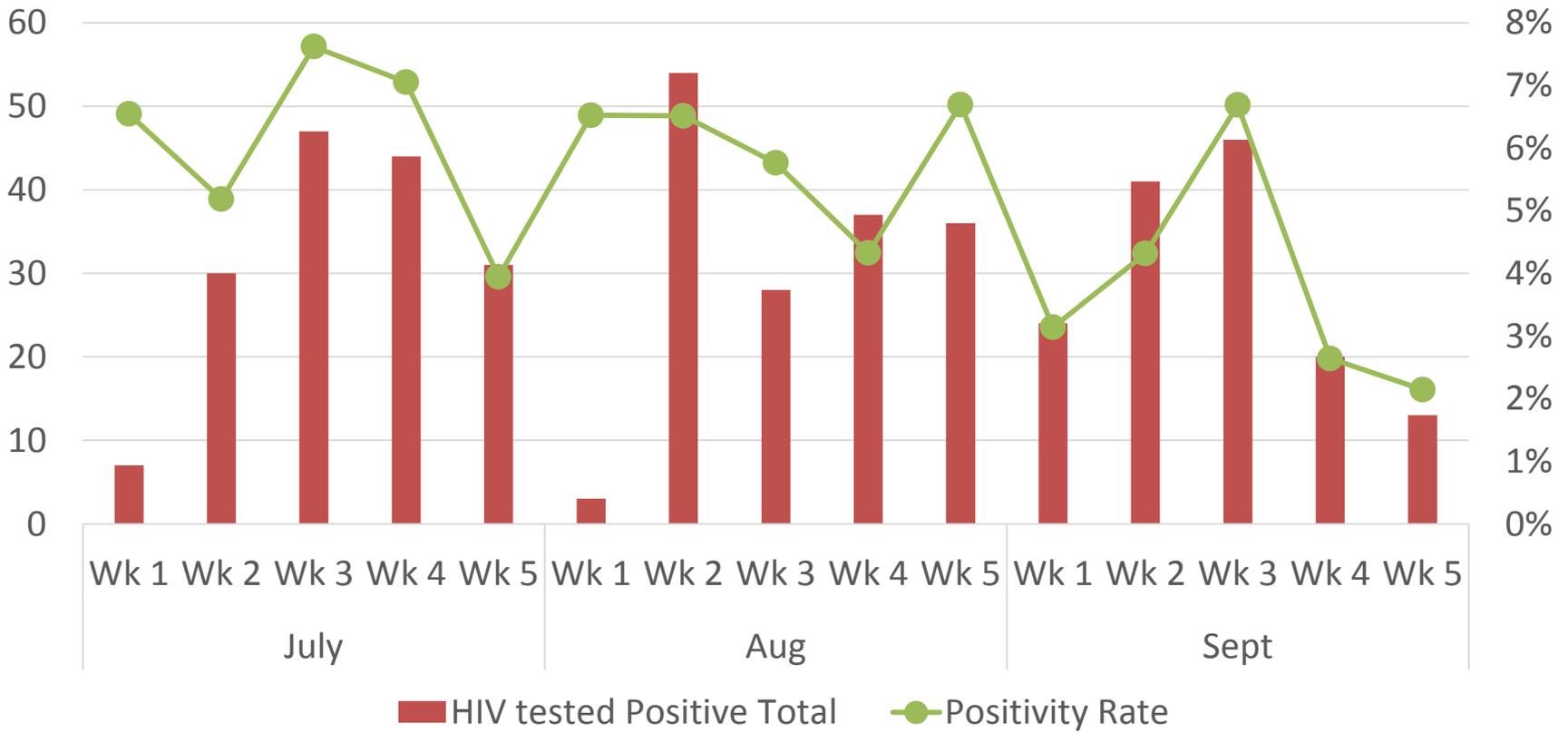
CBCT is seeing different yields depending on where and how we test (2/4)

HCT yield and positivity rates per modality: example of two districts implementing two modalities



CBCT is seeing different yields depending on where and how we test (3/4)

Changes in weekly HIV Yield and positivity rates:
example Tshwane District weekly HIV yield by mobile units

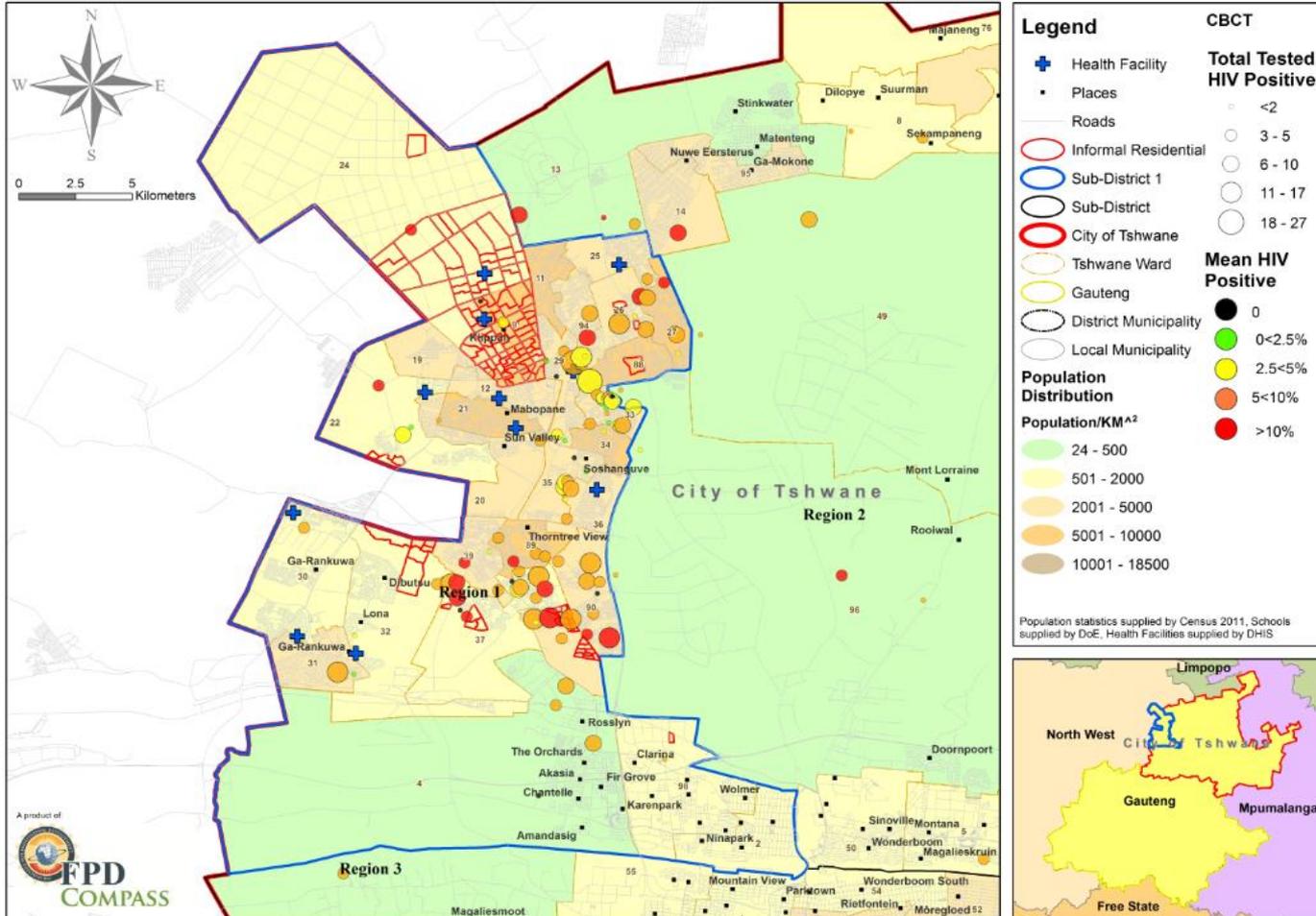


Note: Weeks 1 & 5 may not have 5 working days



CBCT is seeing different yields depending on where and how we test (4/4)

City of Tshwane: Sub-District 1: Mean HIV Positive Rate vs Total Tested HIV Positive Yield (CBCT) (October 2014 - March 2015)



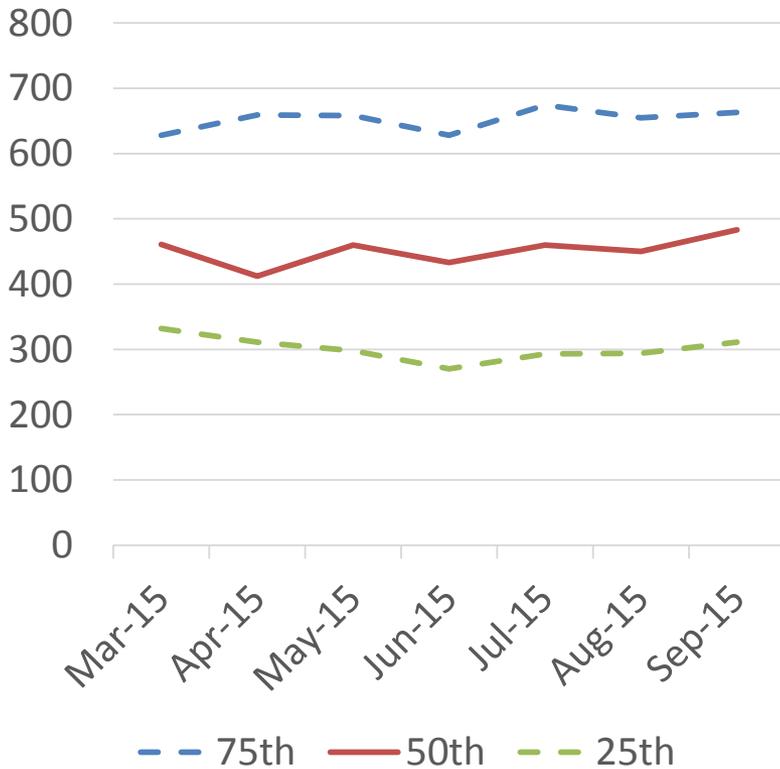
Within a single sub-district, we are identifying “hotspots” and “cool spots”

What we need to understand about the cools spots are:

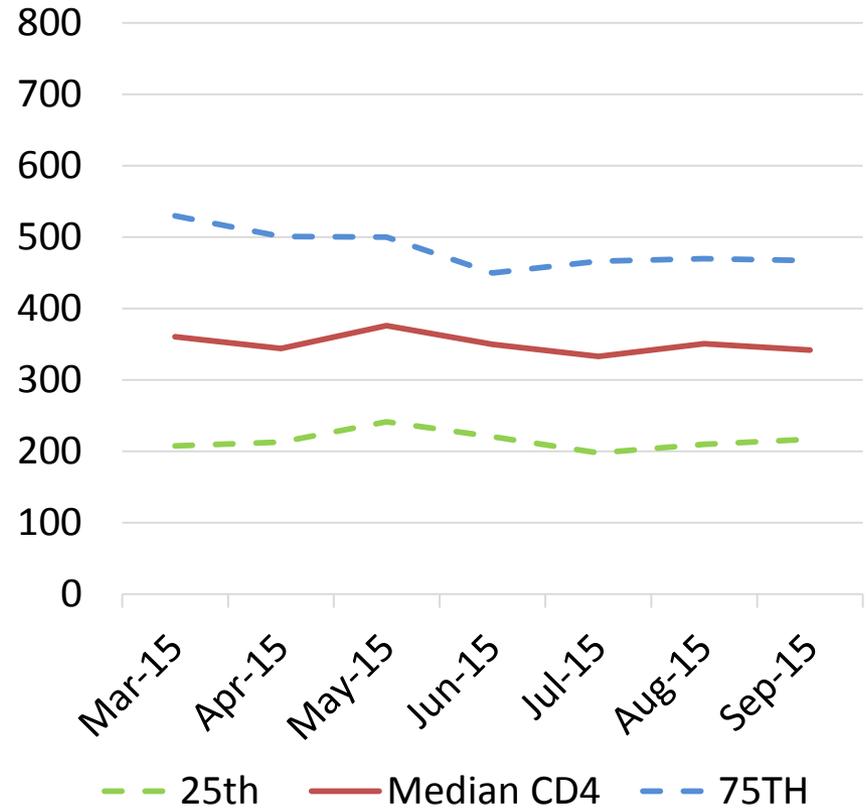
- What’s the known positivity coverage?
- Are we reaching the “right” clients?

CBCT is reaching people with a relatively high CD4 count (reaching 1st 90 early)

Median Point of Care CD4 (Mobile HCT HIV positive clients in four districts)

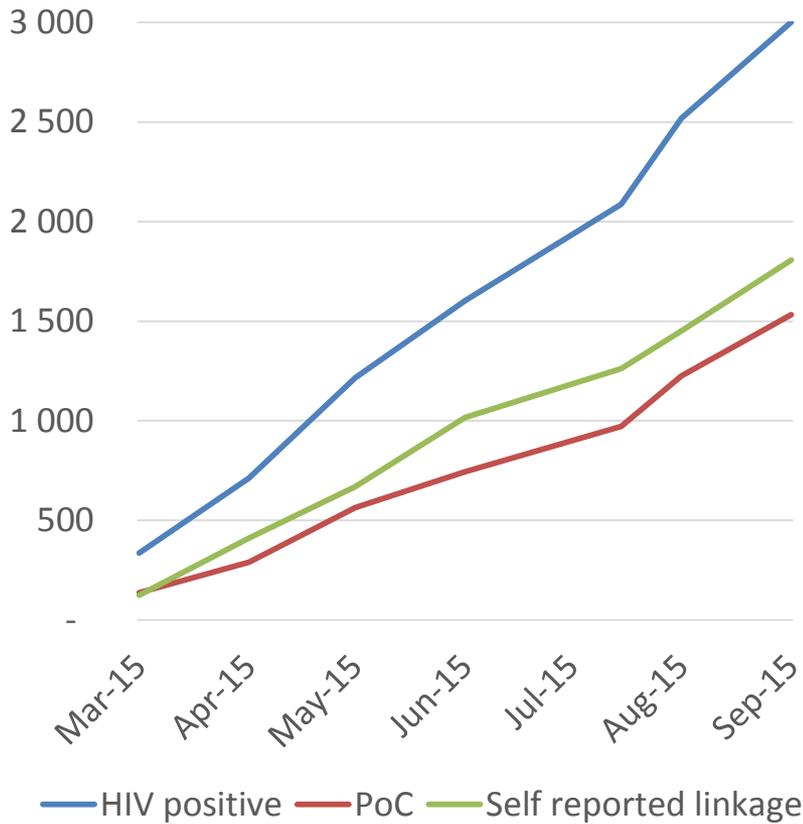


Median in-facility CD4 count (HBHCT HIV positive clients in 3 districts)



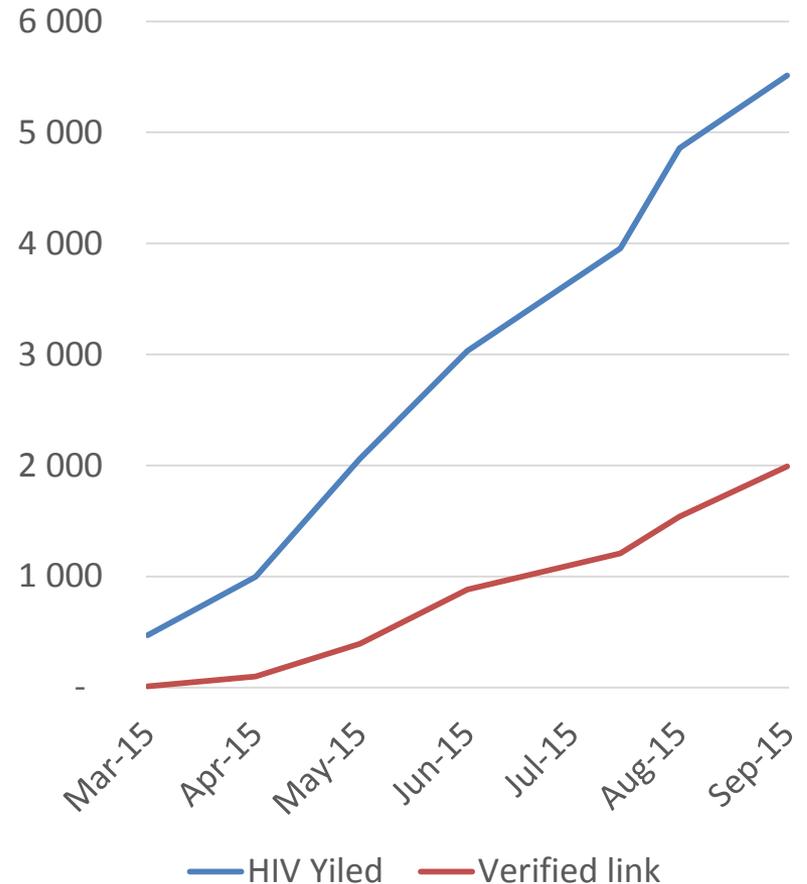
Point of Care CD4 and Linkage tracing is improving following QI interventions

Self-reported Linkage to care mobile HCT (four districts)



60% self-reported linkage; 51% PoC CD4 uptake

Verified in-facility linkage to care Home Based HCT (three districts)



36% linkage to care



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What we are learning about different modalities & package of services

- Different populations access different modalities:
 - Mobile HCT is resulting in high rates of adolescent and male HCT uptake
 - Home based HCT has a much higher uptake by adult women
 - Within a single region, positivity differs between modality
 - ***Learning to mix modalities (SHBHCT, Mobile, Workplace) for optimal saturation and yield***
- Within a single area, we are seeing significant differences in HIV yield and HIV positivity (hot spots & cool spots)
 - Identifying and testing venues for both HCT numbers and HIV yield numbers (and high positivity rate)
 - Developing stronger understanding of local context and better understanding of extent of already known HIV positive (HCT coverage) to help explain unexpected cool spots
 - ***Increasing access: combination implementation; more weekend and after hours HCT; more appointment HCT with focus on couples counselling***

Best practice Linkage

- Multiple layers of tracing are needed:
 - Self-reported:
 - Home-based visits,
 - Call centre follow up/telephonic follow up
 - (to-be-introduced) USSD self-reported referral completion app
 - Verified linkage:
 - In facility referral slips,
 - register review (bloods book, pre-ART/ART register (tier.net))
- Key success factors:
 - Focused counselling on importance of timely referral uptake (and importance of knowing CD4) as part of basic package of services
 - Referring to a designated person in the health facility to assist to navigate the process
 - Enrolment of all sites on PT including strict implementation of IQC

Best practice for 1st 90

- QA for rapid testing essential:
 - Enrolment of all POC CD4 machines on PT
 - Participation on HIV PT scheme
- Implementation of IQC at every site:
 - Maintaining strict IQC at community settings
- Focused post test counselling on test results

CBCT team working to reach 90-90-90

