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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CBCT Project Overview

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

Prime Recipient

Sub Recipients

[Logos of FPD, SFH, and HUMANA]
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;
• eThekwini, 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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CBCT has good uptake by priority pops: AGYW and men (Oct 2014-Sept 2015) (1/2)

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

<table>
<thead>
<tr>
<th>Age Group</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>16.95</td>
<td>17.01</td>
</tr>
<tr>
<td>5-9</td>
<td>17.47</td>
<td>18.61</td>
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<tr>
<td>10-14</td>
<td>35.20</td>
<td>41.03</td>
</tr>
<tr>
<td>15-19</td>
<td>247.04</td>
<td>350.59</td>
</tr>
<tr>
<td>20-24</td>
<td>310.20</td>
<td>480.89</td>
</tr>
<tr>
<td>25-49</td>
<td>226.94</td>
<td>256.81</td>
</tr>
<tr>
<td>50+</td>
<td>97.92</td>
<td>84.20</td>
</tr>
</tbody>
</table>

South African population pyramid (target districts combined)

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

M, 97
393

F, 122
279

HIV positivity rate by sex and age group

HIV testing ratio by sex (F/M)

Total: 1.3
50+ 1.1
25-49 1.1
20-24 1.5
15-19 1.1
10-14 1.1
5-9 1.1
1-4 1.0

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Sex distribution of CBCT clients per district

Capricorn
- Male: 54%
- Female: 46%

Bojanala
- Male: 45%
- Female: 55%

Sedibeng
- Male: 50%
- Female: 50%

Tswane
- Male: 49%
- Female: 51%

BCM
- Male: 40%
- Female: 60%
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%

* 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

<table>
<thead>
<tr>
<th>District</th>
<th>HCT Yield</th>
<th>HIV Yield</th>
<th>Positivity Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhlanzeni Mobile</td>
<td>461</td>
<td>3.7%</td>
<td></td>
</tr>
<tr>
<td>Enhlanzeni HBHCT</td>
<td>242</td>
<td>1.2%</td>
<td></td>
</tr>
<tr>
<td>COJ Mobile</td>
<td>464</td>
<td>3.5%</td>
<td></td>
</tr>
<tr>
<td>COJ HBHCT</td>
<td>601</td>
<td>4.9%</td>
<td></td>
</tr>
</tbody>
</table>
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)

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

What we need to understand about the cool 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)
Point of Care CD4 and Linkage tracing is improving following QI interventions

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

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

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

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 1\textsuperscript{st} 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