



Outreach Testingⁱ & Youth Clubsⁱⁱ:

Lessons Learned from MSF South Africa Experience Across the HIV Cascade of Care

Best Practices and Innovations in Reaching and Linking Adolescent Girls and Young Women Meeting
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Context: Two MSF-led interventions for AGYW

Eshowe/Mbongolwane, KwaZulu-Natal: Outreach Testing

- Population of ~114,000 in Wards 1-14 of uThungulu District (uMlalazi Municipality)
- “Bending the Curves” project: evidence-based interventions & innovative strategies to decrease incidence of HIV/TB, and reduce morbidity & mortality; especially targeted at youth, ages 15-29
- MSF supporting District & Provincial Dept. of Health since 2011

Khayelitsha, Western Cape: Youth Clubs

- Peri-urban township of ~500,000 people outside Cape Town
- Site C Youth Clinic: City of Cape Town-run, youth-targeted PHC facility, targeting ages 12-25. One of two youth-friendly facilities in Khayelitsha
- MSF supporting City of Cape Town and Provincial Dept. of Health since 1999

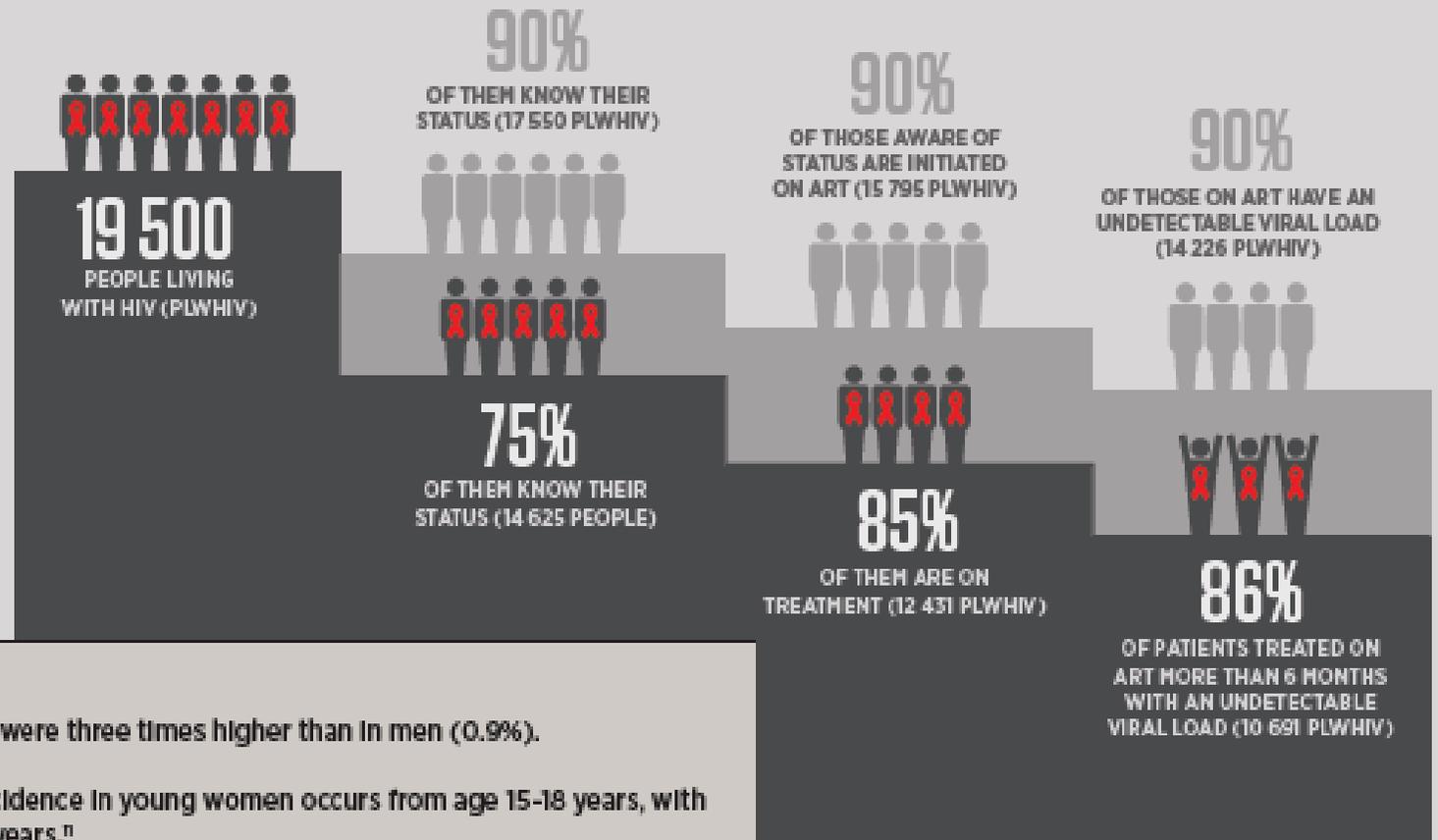
Outreach Testing



CASCADE OF CARE, MSF ESHOWE PROJECT, Q2 2016

HIV CARE FOR EPIDEMIC CONTROL: AMBITIONS VS REALITY

— **Ambition** (UNAIDS official goal by 2020 [8])
 — **Reality** (Results in Eshowe project, population target = 114 000)



- Approaching 90-90-90 in catchment area
- Target population of 15-29-year-olds based on findings of 2013 population survey
- Achieving first 90 requires outreach and facility-based testing



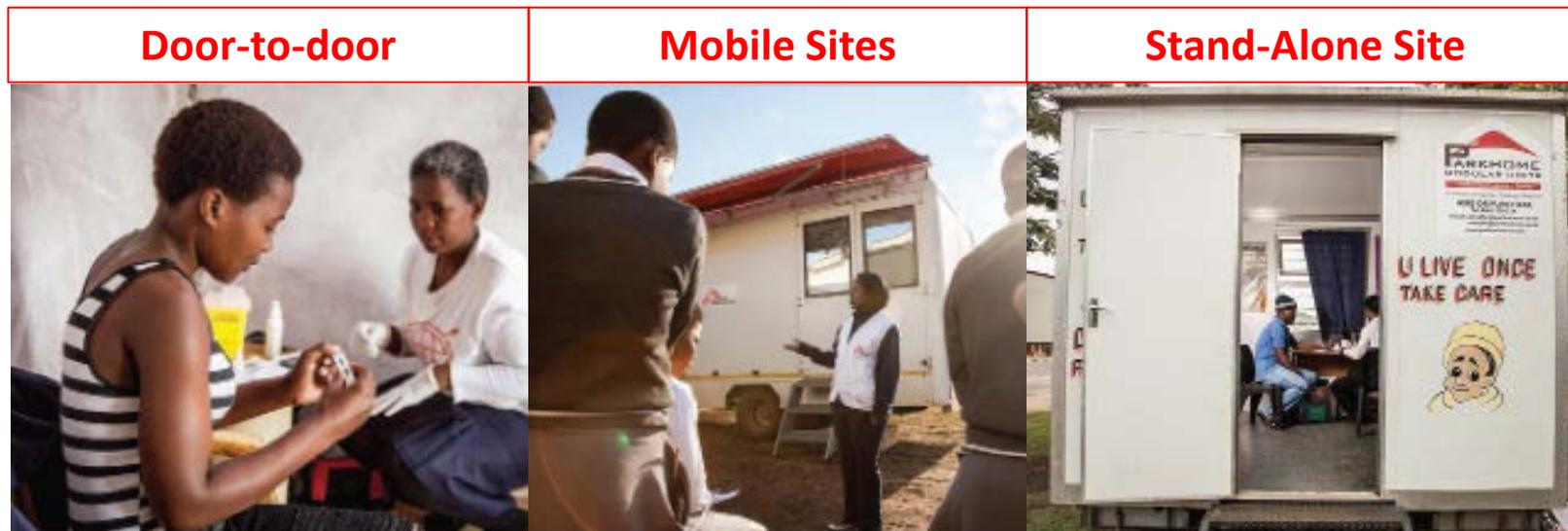
Among young people, age 15-29

New infection rates in women (2.9%) were three times higher than in men (0.9%).

The most dramatic increase in HIV incidence in young women occurs from age 15-18 years, with a peak at 19 years of 6.2/100 person years.¹¹

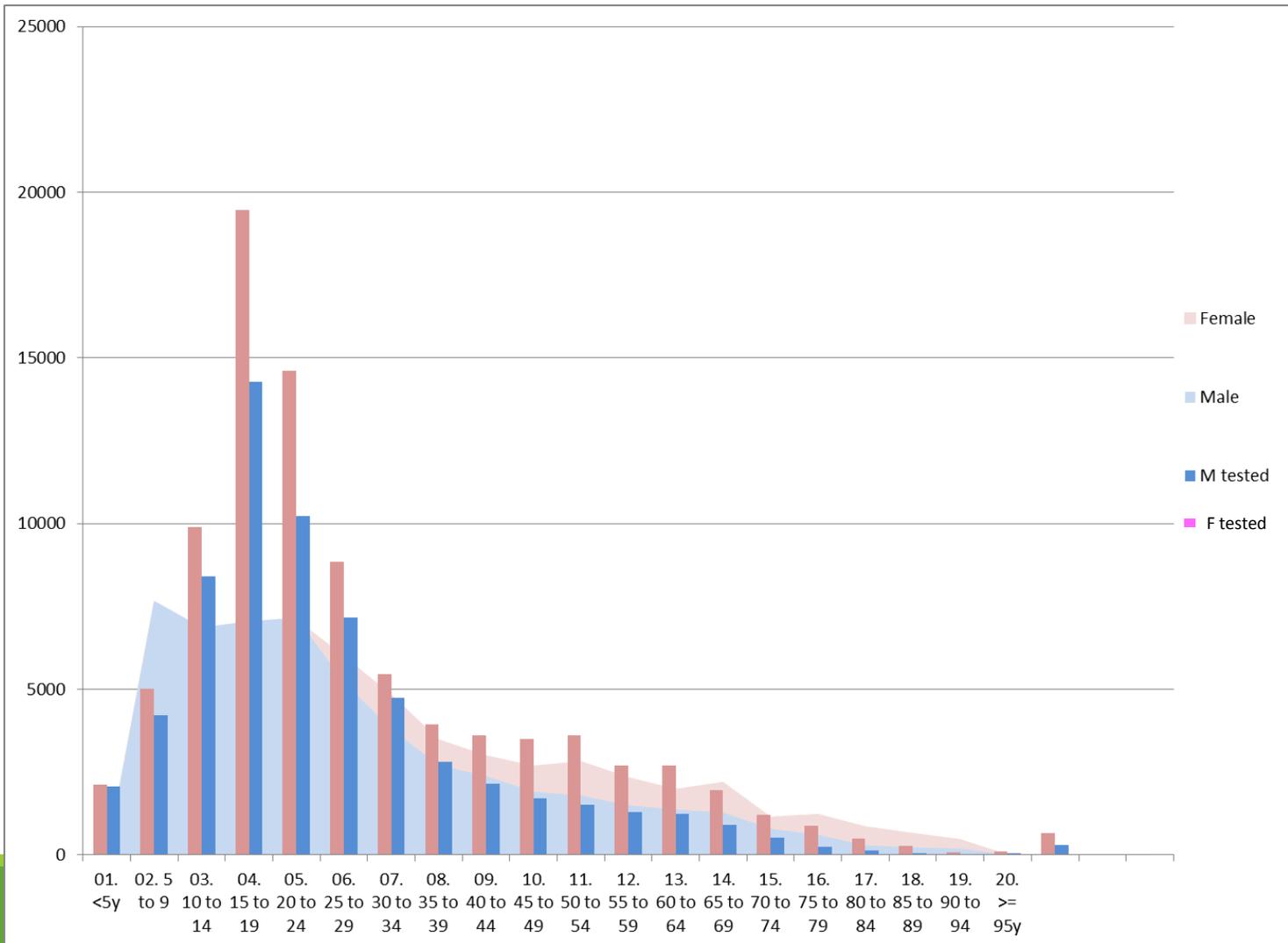
Outreach Testing

- **Three modalities** piloted in the catchment area carry out **HCT and other services** (TB & STI screening, Pregnancy testing, Condom distribution, health promotion, MMC mobilisation)
 - Door-to-door testers also do defaulter tracing/referral to health facilities
 - Some mobile & stand-alone sites have nurses to treat minor ailments, distribute chronic meds



All community testing carried out by over 100 CHW or lay counsellor equivalents— targeted at population, age 15-29

All Outreach HIV testing modalities in Eshowe/Mbongolwane, KwaZulu-Natal, 2013-2016 Q2



2015 Statistics (Females, 15-29)

- Estimated population 17,920
- 15,631 outreach tests conducted (34% of all tests)
 - Individuals could re-test

Door-to-Door: 198 HIV+
(2.7% of 6700 tests)

Mobile/Stand-alone: 470 HIV+
(6.5% of 6500 tests)

Total Unit Cost per Testing Model, Eshowe/Mbongolwane, KwaZulu-Natal, 2014/2015

Figure 5

Cost per client tested by ingredient category & status in each model

	STAND-ALONE SITES (2014)		MOBILE TESTING (2014)		DOOR TO DOOR (2015)	
	HIV-	HIV+	HIV-	HIV+	HIV-	HIV+
TOTAL TESTED	6613	488	11182	388	36256	502
DIAGNOSTICS	R 17.70	R 36.13	R 17.70	R 36.13	R 17.70	R 36.13
STAFF	R 85.57	R 117.84	R 77.50	R 111.63	R 58.54	R 95.25
SENSITIZATION	R 1.13	R 1.13	R 0.69	R 0.69	R 0.22	R 0.22
INFRASTRUCTURE	R 3.55	R 3.55	-	-	-	-
TRANSPORT	-	-	R 16.99	R 16.99	-	-
COMMUNICATION	R 1.60	R 1.60	R 1.32	R 1.32	R 3.24	R 3.24
EQUIPMENT	R 1.18	R 0.10	R 1.07	R 1.07	R 0.17	R 0.17
UNIT COST PER MODEL	R 110.73	R 160.35	R 115.27	R 167.84	R 79.87	R 135.01
TOTAL COST PER MODEL	R 732 235.84	R 78 776.61	R 1 288 966.97	R 65 120.12	R 2 895 703.09	R 67 579.37

* All costs in South African rand. HIV- individuals have one test, HIV+ individuals have two tests.

- **SA Investment Case:** R82 for an HIV-negative diagnosis, and R90 for an HIV-positive diagnosis
- **Staff the greatest driver of cost** in outreach testing modalities (67-77% of total cost)
- **Qualitative benefits:** reaches people earlier in disease progression, reduces stigma

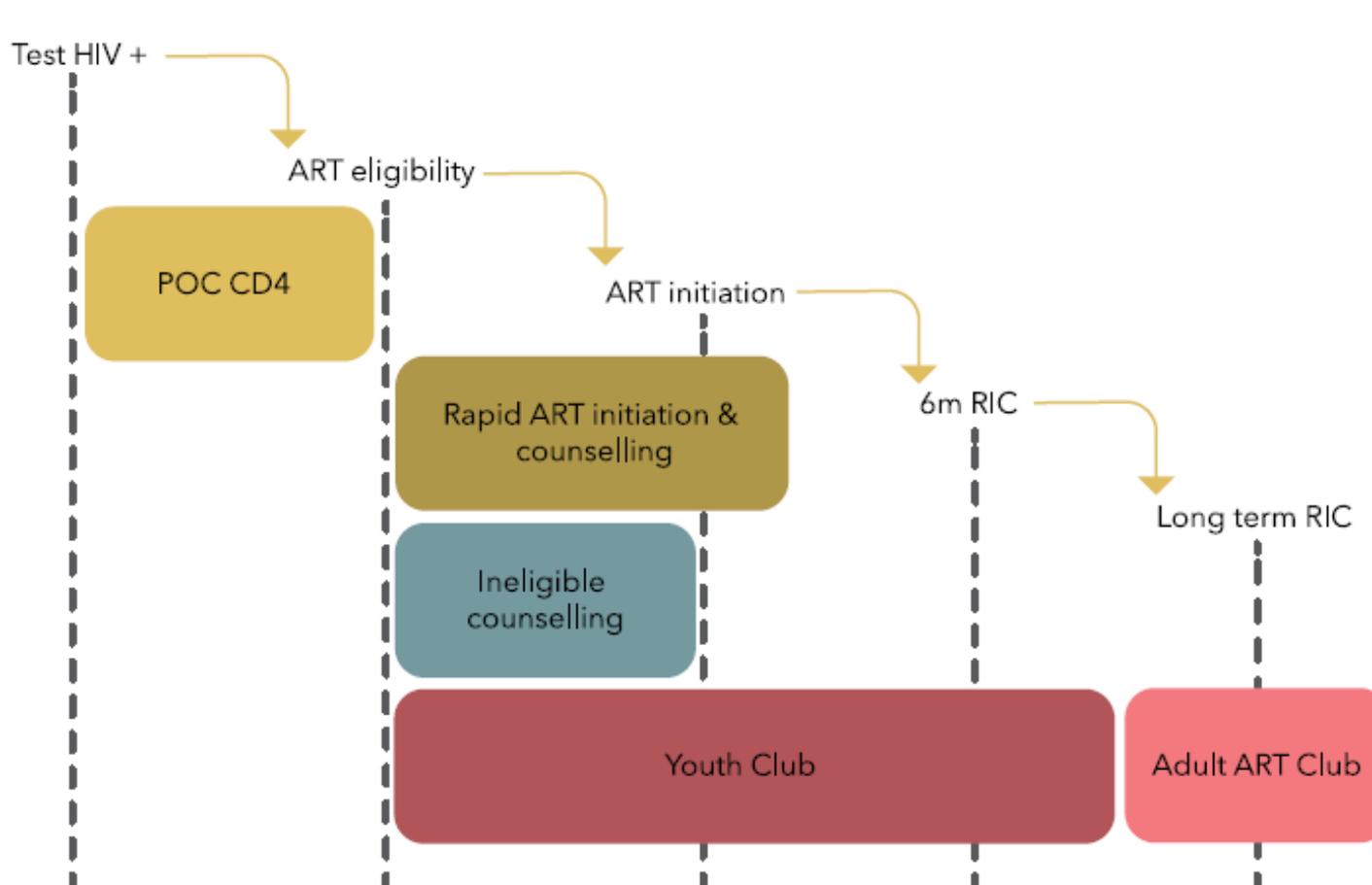


Youth Clubs



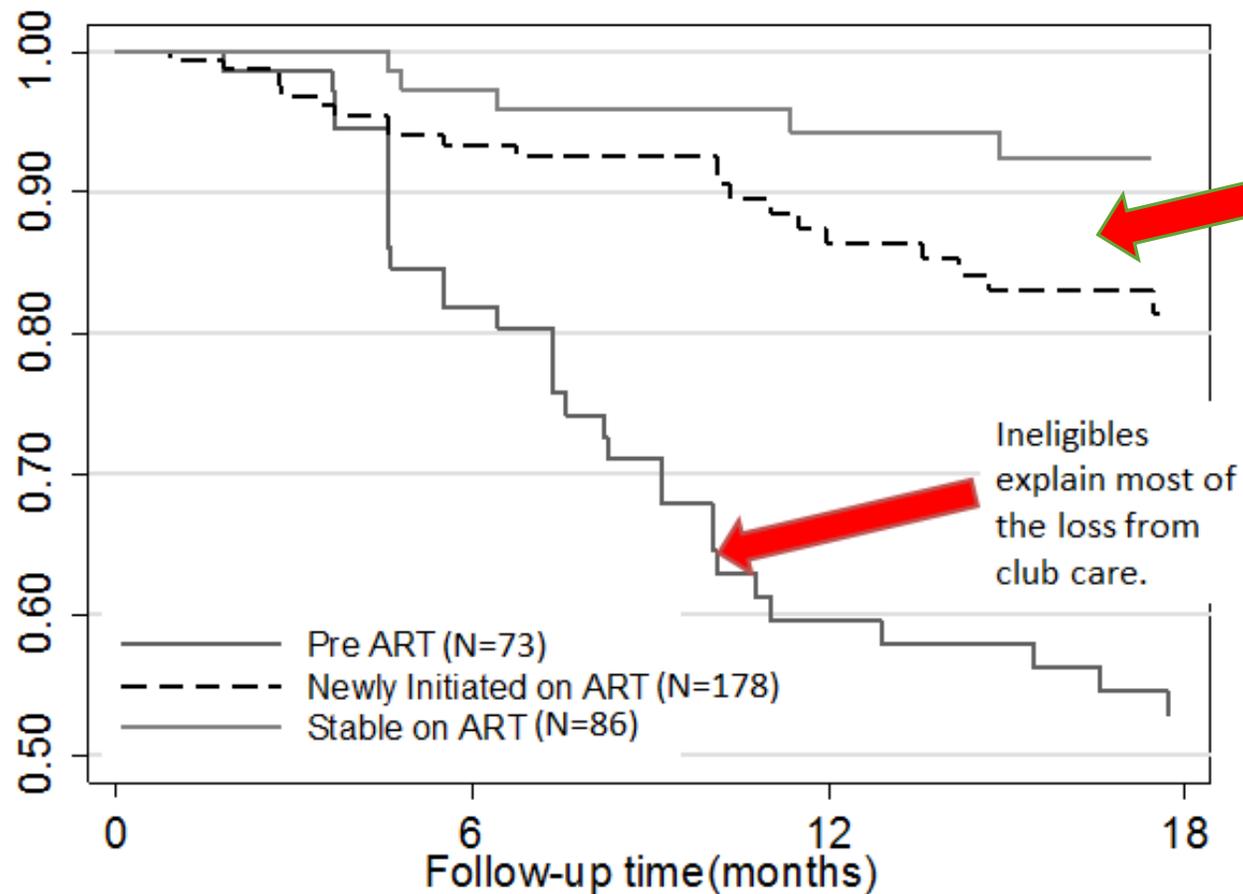
CITY OF CAPE TOWN
ISIXEKO SASEKAPA
STAD KAAPSTAD

Site C Youth Clinic Model



- March 2012-May 2015: HIV-positive youth invited to enroll in **counsellor-led facility-based youth clubs** of ~20 ppl
- Clubs include combo of youth **ineligible for ART, newly initiated, and stable on ART**. Separate groups for youth still in school, older youth.
- Integrate **psychosocial support**, HIV clinical management (including ART initiation), family planning and ART refills.
- **Transition as group** to adult ART adherence club.

Retention by ART Status at Club Start



Summary: Youth Club RIC Outcomes

ART ineligible youth

• **52.9%**
(95% CI 40.0-64.2)

Newly ART- initiated youth

• **86.4%**
(95% CI 78.7-91.4)

Stable on ART youth

• **94.3%**
(95% CI 85.4-96.8)

- Total RIC: Overall retention at 12-months was **81.7%** [95% confidence interval (CI) 76.4-86.0]
- **Good 12-month retention outcomes for youth newly initiated on ART and those stable on ART**
- LTFU among ART-ineligible cohort becomes less relevant with shift to Test & Treat
- Viral load outcomes currently being analysed
- 48% of Youth at Site C Youth on ART are currently in Youth Club. **86% of those in a Youth Club are female**

Conclusions & Recommendations

As South Africa finalizes a new National Strategic Plan for HIV/TB/STIs, note that:

Outreach Testing increases uptake of HCT among youth, age 15-29: Recommend every sub-district has at least one form of outreach testing, according to local epidemic and context. HCT occurs in 100% of schools.

Youth Clubs have high 12-month RIC in youth on ART, age 12-25: Recommend each primary healthcare facility to offer youth-friendly minimum standards, in line with WHO 2015 guidance, including group model of ART management from treatment initiation.

Employment of Community Health Workers and Counsellors essential to affordability and feasibility of outreach testing, facilitating youth clubs, and other tasks in HIV care: Recommend National Department of Health develop policy guidance on job descriptions and tasks carried out by these cadres, complemented by standardized training curriculums and sustainable financing.

Thank you!



Youth Club in action led by Thembi Dutyulwa, youth lay counsellor.

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