

# A STRATEGIC MIX

A strategic mix of approaches to HTS service delivery is required to increase the proportion of people living with HIV who know their status. The goal of this mix is to facilitate the diagnosis of as many people living with HIV as early as possible, maximizing yield, efficiency, cost effectiveness and equity. By carrying out the situation analysis (Part 3), the mix of HIV service delivery models should be implemented,

focusing on those who remain undiagnosed and populations most vulnerable to HIV acquisition.

The following two case studies illustrate a summary of the decision-making processes in two settings to determine the strategic mix of HTS models implemented.

## Strategic mix example 1:

### Low HIV prevalence; low HIV testing coverage; ART coverage 40%

HIV prevalence in the 10 provinces of a hypothetical country ranges from 0.7% to 2.7%. HIV prevalence among clients attending STI clinics is 7%, among sex workers 13% and among men who have sex with men 17%.

From the most recent demographic and health survey (DHS), an estimated 15% of men know their status versus 40% of women. In the past year, 80% of all HIV tests performed were in pregnant women in ANC where HIV testing is done on an opt-out basis.

PITC at all clinic entry points is advocated for, but data shows that less than a quarter of STI clients receive an HIV test versus 70% of TB clients.

Surveys of key populations in the capital reveal that only 30% of sex workers and 25% of men who have sex with men know their HIV status.

A mapping of HTS services is carried out through a desk review and site visits using the questionnaire in Appendix 3:

- HIV testing is promoted and offered systematically at ANC and TB clinics.
- In the past 12 months, there have not been any ministry of health led campaigns promoting HIV testing and nothing specifically directed at key populations.
- Although HTS is promoted in OPDs and STI clinics, the majority of sites (85%) do not have anyone within the clinic trained to test, and there are limited supplies of test kits.
- Last year, no community-based testing was carried out.
- HTS services have been differentiated in an NGO pilot for sex workers and men who have sex with men (provided at night time and at places where they gather in the community), but peers are not engaged in mobilization and testing.
- No specific guidance on how to link HIV-positive clients to treatment or prevention services is available, and

testing sites included in the survey do not systematically assess HIV risk.

### Strategic mix of HTS services (mobilizing, testing and linking) proposed:

#### MOBILIZING

**Build:** Index client testing of any identified HIV-positive case should be ensured through partner notification and be offered both at the facility and in the community. Community-based index client testing may be offered through engaging community cadres to perform HIV tests or through distribution of HIV self-testing kits.

**Adapt:** Train key population peers to create demand for HIV testing and prevention services.

**Drop:** Promotion of testing for general asymptomatic population in OPD to focus on those with symptoms of HIV, TB or STIs.

#### TESTING

**Adapt:** Facility-based provider-initiated testing and counselling (PITC): All clients presenting with STI and TB symptoms and clients presenting with symptoms and signs of HIV should be tested with priority.

**Build:** Offer HIV testing services in workplaces, such as military institutions or security firms (see an Example 2 on page 27), to increase testing among men.

#### LINKING

**Adapt:** Utilize trained key population peers to support peer navigation linking clients with prevention and/or ART initiation

**Build:** Develop an SOP with clear timelines and methods for linking clients to prevention and treatment both at the facility and community to standardize this process. Adopt the WHO rapid initiation guidelines.

## Strategic mix example 2:

### High prevalence; high HTS coverage; ART coverage 78%

HIV prevalence in this hypothetical country is 15.5%. A community-based survey in a selected province, where differentiated testing strategies are being considered, showed that, overall, 86% of people living with HIV knew their status: 91% of women knew their status versus 78% of men. Coverage among young men aged 15-24 years was much lower, at approximately 50%. HIV prevalence in sex workers was estimated at 73%, and an estimated 40% knew their status.

A review of current HTS services using the questionnaire in Appendix 3 demonstrated that:

- PITC is offered at all entry points within hospital settings and all PHC clinics have staff trained to perform HTS. Of TB patients, 95% were tested for HIV versus 75% of STI clients.
- Partner notification and index client testing is not performed systematically and where it is partners are just invited to the facility.
- Last year, four mobile outreach testing campaigns were held for the general population, but with low yield (1.7% of tests performed had an HIV-positive result).
- HTS has not been differentiated for adolescents and young adults or key populations.
- HIVST has not been implemented.

**For the following year, the following strategic mix of HTS services (mobilizing, testing and linking) is proposed:**

#### MOBILIZING

**Build:** Improve partner notification and index client testing including community based index client testing.

**Build:** Launch HTS campaign in colleges and universities; including the introduction of HIV self test kits.

**Build:** Mobilize key populations for testing through trained peers.

#### TESTING

**Adapt:** Continue with facility-based PITC, but with emphasis on risk assessment prior to any re-testing and improve rates of HIV testing in clients with STI symptoms.

**Adapt:** Promote key population testing through distribution of HIV self-test kits by trained key population peers and provide during moonlight hours.

**Build:** Introduce routine HIV testing services in workplaces, such as military and security firms, to target men.

**Drop:** General population community-based HIV testing.

#### LINKING

**Adapt:** Introduce standard operating procedures for linkage, including peer navigation for specific populations, within health facilities.

**Adapt:** Utilize SMS follow up after community testing of key populations to support linkage to prevention and ART initiation.

Within a given country, the proportion of undiagnosed PLHIV may vary by geography (by province and between rural and urban settings) and population (such as men, KPs, adolescents). This leads to the need for a strategic mix of differentiated HIV testing approaches, as a one-size-fits-all approach will not address country-specific or local challenges. As a result of reconsidering the strategic mix of HTS approaches, **some current testing strategies may need**

**to be reduced or stopped altogether.** In addition, testing frequency may need to be reduced among individuals with a low risk of HIV acquisition.

Further examples of how countries have analysed and developed a strategic mix of testing strategies and tools to support this process are listed in Annex 2 and can be found online at <http://bit.ly/2sVehV5>.

#### Case study 8:

### Lessons in efficiency from testing approaches in prisons, Malawi

HIV testing in Malawian prisons has been differentiated to increase uptake and reflect the three-phase approach to prison healthcare. HIV testing is offered when the prisoner enters the prison, biannually during their stay and at exit. Prisoners are mobilized to have HIV testing through health talks at the prison clinic and by peer educators (prisoners who have had some basic health education training) in the cells. The prison wardens who have been trained in HIV testing and counselling perform HIV testing at the prison clinic.

During the biannual screening where all prisoners are offered HIV testing, if not tested within the past six months, prisoners are organized in groups of 10 to receive information about HIV testing. Each prisoner is then invited individually into the testing room and their full details recorded in the HTS register. The unique identifier number from the HTS register is written onto the test kit and on a paper, and the documented time when the buffer is added. To meet the demand for testing, the counsellor does not wait one by one for each test result. The next prisoner is invited into the room to be bled and the same steps described above carried out. This is repeated for the group of 10.

Using a timer, it must be ensured that no test is read before 15 minutes has passed and no test is read later than 60 minutes from the addition of buffer. Once all 10 prisoners have been bled, each prisoner is then called back individually to receive their result. If a positive HIV test is confirmed, post-test counselling is given and the client is linked to care and treatment services at the prison clinic.

By implementing this model, HIV testing coverage in two central prisons (population of 1,500-2,000 inmates) increased from 43% to 97% and 19% to 96% between 2014 and 2017. Similar adaptations to patient flow have also been documented in OPD and community testing settings.

#### Case study 9:

### Piloting a symptom and risk screening tool during community HIV testing, Tanzania

In Tanzania, ICAP at Columbia University is implementing a CDC PEPFAR-funded community-based HIV prevention intervention, known locally as the FIKIA project (Fikia means “to reach” in Swahili). Testing in the community needs to be specifically targeted to ensure adequate yield, unlike in health facilities where the patient populations are already presenting with illness. ICAP piloted a screening tool as part of a combination of interventions to increase yield and number of HIV positive clients identified through community testing. The screening tool assessed self-reported symptoms and key risks, including: i) whether or not they experienced any symptoms (including fever, lymphadenopathy, mouth ulcers, rash, headaches or sore throat) in the past two months, ii) whether or not the client is a key population member and/or adolescent girl or young woman, iii) contact of an HIV positive index client and iv) whether or not the client suspects HIV exposure since their last test. From the initial results, the screening tool has been incorporated in additional project regions as a method to improve targeting of testing activities particularly with men, large events, and geographically distinct communities such as fishing villages and mining camps.