DIFFERENTIATED CARE

Differentiated prevention and HIV testing for Female Sex Workers, Zimbabwe

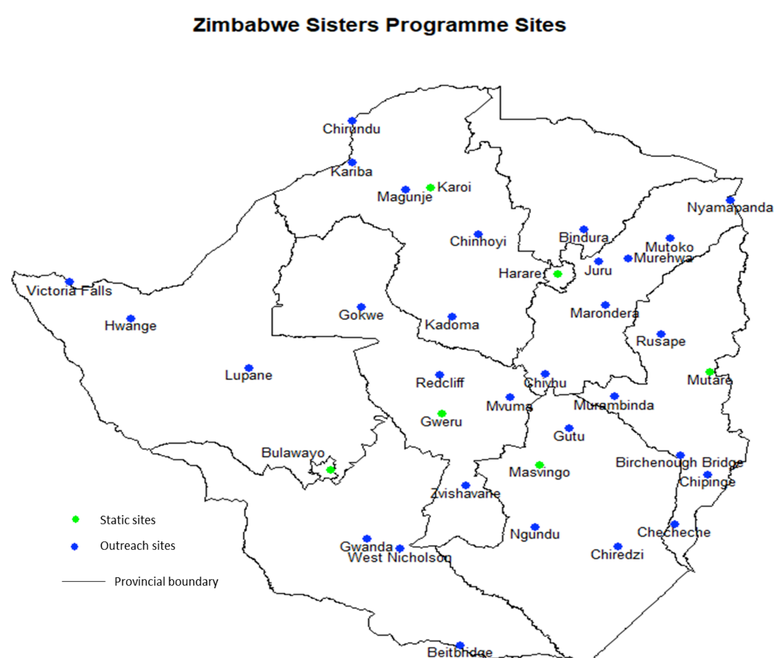
Tendayi Ndori-Mharadze, The Centre for Sexual Health and HIV AIDS Research Zimbabwe (CeSHHAR Zimbabwe), tendayi@ceshhar.co.zw, www.ceshhar.co.zw

OVERVIEW

The HIV prevalence among Zimbabwean female sex workers (FSWs) is four times that of the general population of women at 58%. Between 55-70% of FSWs report knowing their HIV status and less than half of FSWs living with HIV report being on ART. Overall, 65-72% of HIV positive FSWs have a viral load below 1000 copies/ml. Qualitative data suggests that FSWs are marginalised, stigmatised and criminalised. In addition, some FWSs are highly mobile and therefore harder to reach with services.

To address the needs of FSW in Zimbabwe, the Sisters with a Voice programme (Sisters) was established in 2009 to foster an empowered and resilient sex work community fully engaged in the HIV prevention and care cascade. It has been scaled up and is now a national programme with 36 sites (see Figure 1) - six static sites in the major cities and 30 outreach sites along the major highways and hotspots across the country. All sites are nested in public sector facilities. Sisters is a comprehensive programme, which uses a rights based approach and is run in accordance with UNAIDS/ WHO guidance for programming in key populations. The annual HIV incidence estimated among Sisters attenders between 2009-2013 was 10%. The programme is run on behalf of Ministry of Health and Child Care (MoHCC) and National AIDS Council (NAC) and from 2018 is funded by the Global Fund (GF).

Figure 1: Map of Sisters Programme Sites



We work with a strong network of sex worker peer educators and to date have trained 270 sex workers to undertake community mobilisation (in some cases using microplanning) and empowerment activities in the communities they serve. Half of the peer educators have received additional paralegal training. The other half have also received training to provide lay child protection services. Services provided through Sisters' sites include - STI management, condoms programming, HIV testing (including access to self-testing), referral to ART and Pre-Exposure Prophylactic (PrEP) and community-based adherence support.

DIFFERENTIATED CARE

SISTERS WITH A VOICE

The Sisters' programme provides works across the prevention and care cascade providing complimentary services to the health system with programming run by peer educators (see Table 1).

Table 1: Summary of the building blocks of Sisters with a Voice

	Community mobilisation and support	HIV testing	Initiation on ART/PrEP	Maintenance on ART/PrEP
WHEN	At least once a month (Frequency of contact depends on an individual risk assessment – those at high risk are seen weekly, biweekly for those at medium risk and monthly for high risk)	Every three months while HIV negative	Based on HIV testing results	Weekly following ART/PrEP initiation and then monthly
WHERE	SW hotspots (e.g. bar, street, flat or residency, truck stop)	One of the six static sites in major cities*, mobile clinics, outreach clinics	For ART± - PSI new start centre or public health centre For PrEP - PSI	Sisters' Clinic and community – home, work place (bar, street, truck stop)
WHO	Peer educators	Nurse counsellor or sex worker in the case of self-testing	Physician led for PSI and a mix of physician and nurse led for Public sector ART sites Peer educators for adherence support	Nurse Counsellors, Outreach Workers and Peer Educator
WHAT	Encouragement to link to services and attended scheduled clinical appointments, participatory activities aimed to build resilience and social cohesion, mobilisation for regular HIV testing	HIV testing, supported referral for either i) ART to public sector clinics or ii) PrEP to PSI clinics	ART and other clinical needs PrEP and other clinical needs	Adherence Sisters programme - community-based programme aimed at building a 'sisterhood' for adherence support Self-help group intervention – building financial literacy, resilience (including psychosocial) and social cohesion

* An option for self-testing is also provided
± Sisters does not provide ART services on site bur offers referral

Microplanning
An additional programme, Microplanning, is currently being piloted in Harare. Twenty-five peer educators have been recruited, trained and each assigned to a hot spot. The caseload is 50-women/peer educator. The training material was developed together with the sex workers in an iterative process. Weekly meetings are being held with each peer educator to review the tracking tools (a list the names of women to be seen and the topics/ issues to be discussed e.g. clinic appointment). A mobile phone application to assist with data guided microplanning is under development. The microplanning pilot is being funded by Bill & Melinda Gates Foundation (BMGF) and the HIV testing services through UNFPA through the end of 2017 we anticipate funding from the GF in 2018. The feasibility of this programme is heavily reliant on tracking linkages between referrals, the system for which is not yet perfect.

DATA

Data collection and challenges

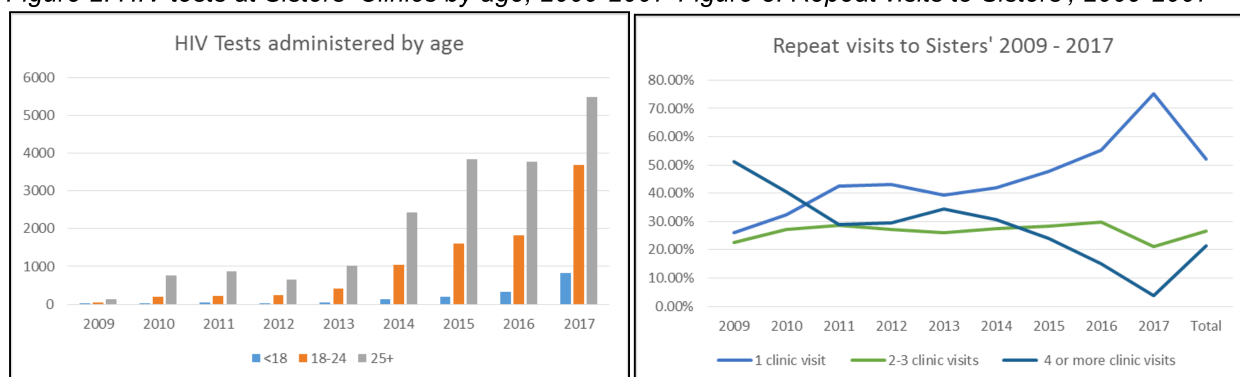
Sisters' has collected detailed records on all women attending the service since inception in 2009. Since 2013, data has been captured electronically using a system developed by RTI International and based in the coconut platform. Open Data Kit (ODK) ODK and District Health Information Software 2 (DHIS) 2 is used to collate clinic based outreach data. Since the start of the programme, each sex worker has been assigned a simple alphanumeric identifier that has been used to track her within the Sisters programme. More recently this has been linked to a more complex unique ID, which has the potential to identify women attending different services. The longitudinal data has allowed in-depth analysis of programme attendees to estimate population incidence and population size.

Our data system is not linked to the MOHCC Electronic Patient Management System (EPMS) so we are currently using referral slips to link women between HIV testing services (HTS) and ART programmes. This system has challenges as referral slips can get lost making it difficult to track the women. We are exploring the possibility of establishing secure, one-way linkages between the Sisters' database with that of the MOHCC and other public health provides (e.g. city health departments) so we can more effectively track the women who are accessing services between the two organizations.

Results

The Sisters' program has grown considerably since it started in 2009. By the end of 2017, 58,000 women had been seen at the programme clinics. The proportion of young women who are accessing services through Sisters' has increased over time with an increased number of FSWs testing for HIV year on year (Figure 2). Despite the increase in number of FSWs reached, data on return visits highlights that there is non-attendance to regular clinical visits. Figure 3 highlight the proportion of women who visit the clinic once, 2-3 times and 4 times over the project life.

Figure 2: HIV tests at Sisters' Clinics by age, 2009-2007 Figure 3: Repeat visits to Sisters', 2009-2007



In 2017, the results from the Sisters Antiretroviral Therapy Programme for Prevention of HIV, an Integrated Response (SAPPH-Ire) Trial was published[1]. The study compared the standard Sisters programme to a more intensive intervention (SAPPH-Ire). Between 2013 and 2016, engagement with services improved markedly in both arms of the trial (see Figure 4).

Results from the SAPPH-IRe trial endline survey showed that the 72.4 % (95% CI 63.8-76.7%) of HIV infected FSW in the more intensive SAPPH-IRe arm were virally supressed (viral load <1000 copies/ml) compared to 67.8% [95% CI 60.1%-73.4%] in the Sisters only arm (an adjusted risk difference of 6.1% (95% CI -0.8%, 13.0%, p=0.07). The results from the Zimbabwe Population–Based HIV Impact Assessment (ZIMPHIA) show viral suppression among adult women in the general population to be 64.5% [95% CI 62.2-66.7%][2]. The SAPPH-IRe intervention (intensive community mobilisation, including specific mobilisation targeting young women, regular testing, including through self-testing, community based adherence support using Adherence Sisters Programme) is now being scaled up where resources permit throughout the Sisters programme.

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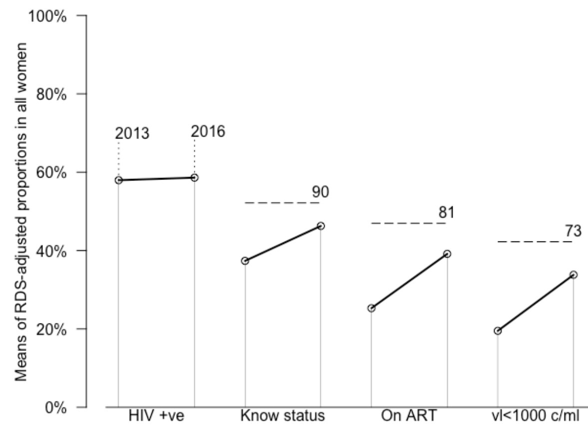
[1] https://www.ncbi.nlm.nih.gov/pubmed/27930599

[2] http://phia.icap.columbia.edu/countries/zimbabwe/

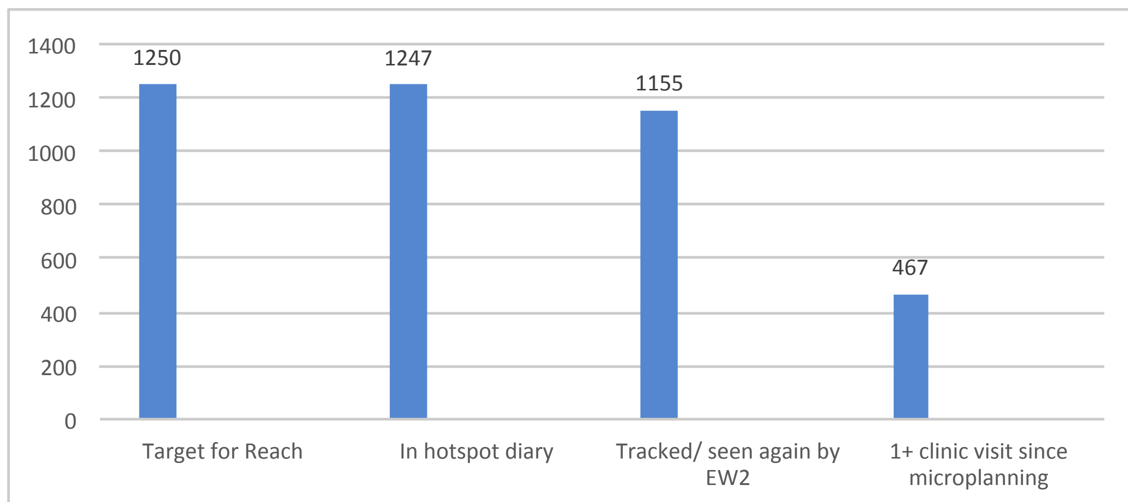
DIFFERENTIATED CARE

Figure 4: Improved cascade among 2,883 FSW from 14 sites in Zimbabwe, 2013-2016



Microplanning pilot
Within the microplanning piloting we are developing an application that can be used by the peer educators during community mobilisation. The application will link with Sisters clinical data (and in time with ART and PrEP clinic data) to show linkage between microplanning and clinic visits. The application will provide a prompt to the Peer educators if a woman in their caseload is due for a clinic visit or a medical check-up. The Peer educator will then follow up with a reminder for the appointment. Figure 5 shows linkages between microplanning and clinic visit from April to December 2017.

Figure 5: Linkage from Microplanning pilot to clinic, April – December 2017



CHALLENGES AND SUCCESS

The volume of FSWs coming through the Sisters' program continues to increase with as many as 60 clients a day. While Our capacity is over stretched, hence we are seeing a decline of women coming for repeat visits over time. The nurse patient ratio is too high resulting in long waiting times and overcrowded clinics. Transport costs to clinics has also been cited as a challenge which results in lower linkage between outreach and clinic visits. Mobile clinics have been introduced but again these can only be conducted biweekly in Harare were hotspots are many.Linkage between microplanning and clinic visits is currently 40% (see Figure 5) we would want to have at least 80% of women reached at community level linking to the clinic.