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Community-Based HIV Testing Services in the Democratic Republic of Congo

HIV TESTING SERVICES IN THE DEMOCRATIC REPUBLIC OF CONGO

The Joint United Nations Programme on HIV/AIDS (UNAIDS) set ambitious targets to end AIDS by 2030. The “95-95-95” targets, indicate that 95% of people living with HIV (PLHIV) should know their status, 95% of identified HIV-positive persons should be active on treatment, and that 95% of people on treatment have a suppressed viral load by 2030. However, only 62% of PLHIV in the Democratic Republic of Congo (DRC) are aware of their status.ⁱ Within this context, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) supports the health system of the DRC by implementing community approaches and strategies aimed at achieving epidemic control.

COMMUNITY-BASED APPROACHES FOR HIV TESTING SERVICES

HOME-BASED HIV TESTING SERVICES

The One-by-Two Approach

Access to modern medical care, including HIV services, is poor in many parts of DRC, resulting in common use of self-treatment and traditional healers. Home-based HIV testing services (HTS) however, bring these services to individuals’ households, overcoming barriers to access by providing testing to individuals who otherwise would not have it.

In its effort to intensify identification of PLHIV who are unaware of their status, IHAP-Kinshasa developed an innovative index case tracing approach. Index clients are individuals newly diagnosed as HIV-positive or enrolled in HIV care and treatment services. Index testing is the voluntary process whereby counsellors or health care workers ask index clients to list all of their children and sexual partners within the past year.ⁱⁱ

Through IHAP-Kinshasa’s “one-by-two approach,” health care providers and lay workers visit the homes of contacts of an index client to administer HTS, along with one bordering household, to avoid potential stigma and discrimination against the index client. Index cases are first identified by

IHAP-supported health facilities, with priority given to newly diagnosed patients and patients with an unsuppressed viral load. Health care workers then engage with the index client to list their biological children as well as any sexual partners. For female index clients, children under age 15 and those identified by a HIV risk assessment tool are tested.

Screening is systematically conducted for these contacts and all households visited receive health promotion messaging on hygiene, HIV, and other related topics. For biological children of male index clients over age 3, an HIV risk assessment tool is used to assess transmission risks and determine whether HIV testing should be conducted. For all newly diagnosed HIV cases, individuals are referred and accompanied to a local health facility for enrollment in HIV care and treatment services.

The Integrated* HIV/AIDS Project – Kinshasa (2017 – 2022)

The Integrated HIV/AIDS Project – Kinshasa (IHAP-Kinshasa) is aligned with achieving UNAIDS 95-95-95 targets by 2030 and places an emphasis on HIV prevention, care, and treatment for priority populations (including those infected with TB, experiencing malnutrition, adolescent girls and young women, children, pregnant women, and men). With funding from United States Agency for International Development (USAID), IHAP-Kinshasa ensures strategic linkages among services both at the facility and the community level to advance the HIV/AIDS response and achieve sustained epidemic control in DRC.

Project Kimia (2013-2019)

Through this U.S. Centers for Disease Control and Prevention-funded project, EGPAF implemented a full range of prevention of mother-to-child transmission of HIV (PMTCT), HIV care and treatment, and TB services, as well as services to support clients affected by sexual and gender-based violence, at 63 health facilities.

Between October 2017 and September 2019, the HIV positivity yield under “one by two” strategy more than quadrupled, from 2.6% to 10.9% (see Figure 1 below).

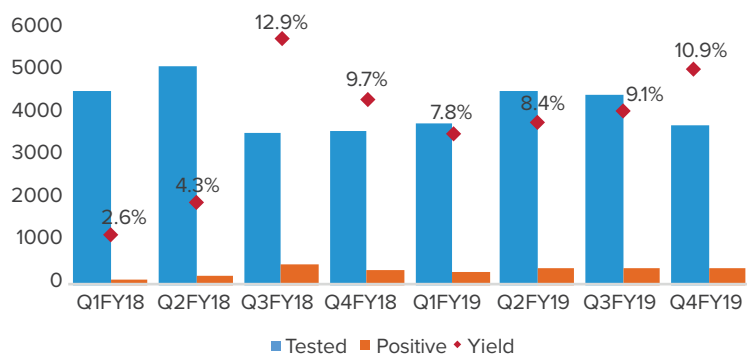


Figure 1: Results for “One by Two” Strategy

HIV Active Case Finding

Community health educators are volunteers who agree to devote part of their time to community-based health activities in their respective communities. Community volunteers are in regular contact with community members through community health activities such as promoting vaccination uptake and identifying potential cases of tuberculosis, polio, malaria, and malnutrition. This role allows them to identify potential HIV cases, as well. Under the “suspected case testing” strategy implemented under IHAP-Kinshasa, community health educators are trained to conduct home visits and to identify individuals in the community who may have clinical signs of HIV or AIDS or may be vulnerable to HIV infection. Clinical signs include prolonged fever, rash, and pronounced and unexplained weight loss.

After the community health educator has identified a suspected case for testing, a team consisting of a peer educator or mentor mother trained in provider-initiated counseling and testing and a health care provider conduct a home visit to this individual. By visiting homes as a team, health care providers promote HIV service delivery as part of a broader health services package, which reduces stigma associated with community health worker visits that are only for HIV-positive clients. Once in the household of the suspected case, the health care worker discusses hygiene, cholera, and Ebola prevention before counseling on HIV prevention, testing, and offering the individual an HIV test. By discussing a wide range of health topics, the team builds trust with households before tackling topics related to HIV.

If the test is positive, they are referred to a local health facility for enrollment in HIV care and treatment, and are in turn considered a new case for further index case tracing.

Between October 2017 and September 2019, this proved to be an effective strategy, with a positivity yield doubling from 11.9% to 22.8%.

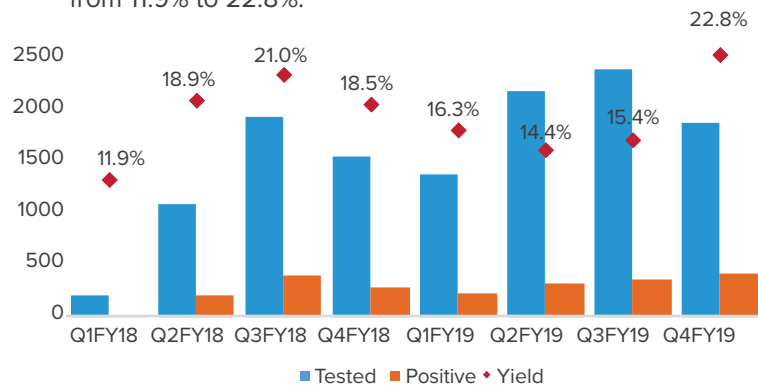


Figure 2: Results for “Suspected Cases” Strategy

HTS OUTREACH WITH MEN

Combined Testing for HIV and Non-Communicable Diseases

HIV prevalence in the DRC is significantly higher among women aged 15-49 (1.6%) than among men the same age (0.6%). This results in an infection ratio between women and men of about 2.7; in other words, there are 267 infected women for every 100 men.ⁱⁱⁱ Despite this, the rate of coverage for screening is slightly higher among women than in men eligible for HTS. EGPAF therefore set up a strategy to reach more men over age 20 by offering HTS alongside hypertension and diabetes screening.

Through this strategy implemented as part of IHAP-Kinshasa, community health workers sensitize men on the importance of screening for diabetes and hypertension and publicizing when and where these multi-disease screening campaigns will take place. At the screening site, providers first offer diabetes and hypertension screening, followed by HTS. Individuals testing HIV-positive, as well as those with high blood pressure or elevated glycemic indexes, are referred to local health facilities for care and treatment.

The HIV positivity yield under this approach increased from 3.1% in January 2018 to 5.7% in September 2019, in spite of an increasingly large population reached by the intervention, as seen in Figure 3.

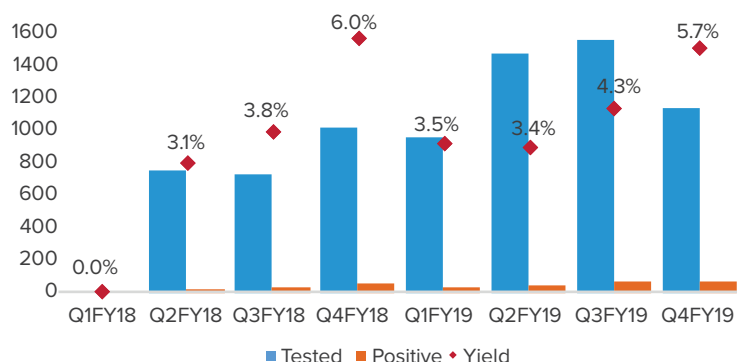


Figure 3: Results for Combined Testing for HIV and Non-Communicable Diseases

Workplace Testing

As part of efforts to increase HIV testing and diagnosis among men, EGPAF implemented a strategy to provide HTS to men in their workplaces under Project Kimia. This approach aligned with the Voluntary HIV Counseling and Testing @ WORK initiative, launched in 2013 by the International Labour Organization, UNAIDS, the International Organization of Employers, and the International Trade Union Confederation.

After identifying various workplaces frequented by men (barbershops, bars, garages, and construction sites), a team of community agents visited these spaces to raise awareness of the importance of HIV testing and offer HTS. Individuals testing HIV-positive are then initiated on ART at the community level or are referred to a local health facility for enrollment in care and treatment. Individuals testing negative are provided condoms.

Between October 2018 and June 2019, workplace testing resulted in persistently high positivity yields, between 13.1% and 16% (see Figure 4 on the next page).

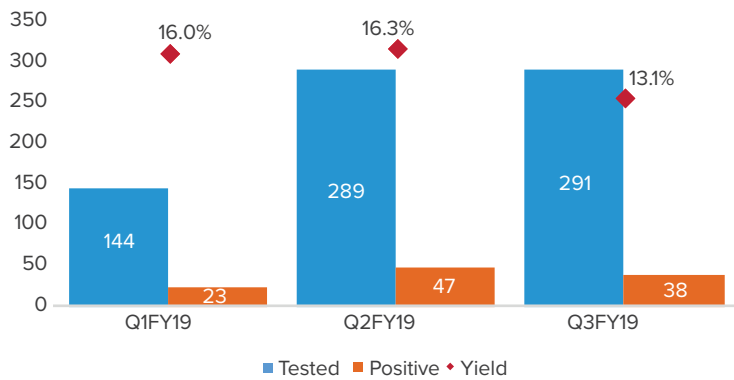


Figure 4: Workplace Testing Results

CHALLENGES, LESSONS LEARNED AND NEXT STEPS

EGPAF faced a number of obstacles while implementing community-based HIV testing services. For example, addresses for sexual partners of index clients often changed; however, EGPAF addressed this by intensifying efforts to locate these contacts through phone calls and home visits in the suspected case strategy. Moreover, based on the guidance of PEPFAR/DRC, EGPAF now defines clients identified for index testing as those who have a sexual partner that is living with HIV or a partner who had died.

Another challenge was that some individuals refused HIV testing for fear of knowing their status or refused to allow their children—in the case of index testing—to be screened. EGPAF is working to increase acceptability of HIV testing by ramping up combined testing for HIV and non-communicable diseases and increasing engagement with religious leaders to educate their parishioners on the importance of HIV testing.

Lastly, a continued challenge has been the low rate of disclosure of an HIV status between sexual partners. EGPAF has found that it is vital to collaborate with index clients on motivating their partners to be tested. By implementing these community-oriented approaches, EGPAF identified the importance of broadening the topics discussed by home visit

teams beyond HIV to build trust and reduce stigma prior to conducting HIV testing.

The EGPAF/DRC team also identified various lessons learned through implementing these community-based HIV testing strategies that will further improve community engagement in broader HIV services. Selection of the right community actors to be engaged in community level activities and adequate motivation of these individuals was vital to the success of these strategies. Moreover, including health care workers in community level activities increased the trust of the population in the accuracy of HIV results and improved linkages to care and treatment, since the providers could initiate individuals found to be HIV-positive during the home visit.

Moving forward, EGPAF/DRC will further expand on the screening for non-communicable diseases to better target testing for individuals most likely to be HIV-positive and unaware of their status. EGPAF/DRC will also strengthen collaboration with religious leaders and staff psychologists in community-based HIV testing strategies to reduce testing refusal.

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