

Community based approach to achieving Universal Access to HIV Testing and Counseling

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Abstract

Introduction: Achieving universal access to HIV services requires a mixture of strategies to increase opportunities for people to know their HIV status. APIN in conjunction with civil society organization and with funding support from Global Fund (GF) and National Agency for AIDS Control (NACA) embarked on community HTC outreach campaigns in Lagos, Plateau and Oyo States of Nigeria. Community entry, advocacy and mobilization were key start up strategies.

Methods/Approach and Result: Partnership with Civil Society Organizations with strong presence leadership roles within the communities was the main approach to a community based approach to increasing uptake of HTC services in the three (3) states of Nigeria where AIDS Prevention Initiative in Nigeria operated. Eighteen (18) LGAs, 189 communities and 154 ANC locations across three states benefited from the outreaches. 54,841 (1.2% positivity rates) people among the general population and 36,061 (0.19% positivity rates) pregnant women were provided with HCT services over three weeks.

Conclusion: Alternative approaches to facility based HTC are critical to achieving universal access to HTC. Community based approach to HTC that relies on strong partnerships and collaboration with organizations that have commitments and leadership roles in the communities can improve uptake of services. It is a veritable approach for expanding access, availability and coverage of HTC services.

Keywords: Community, Partnership, Access, Uptake, eMTCT, Advocacy, Mobilization

Introduction

HIV/AIDS is a major global public health issue responsible for about 39 million deaths worldwide since the beginning of the epidemic (WHO, 2015). Sub-Saharan Africa is the most affected region, with about 24.7 million infected people, which constitutes about 70% of the global burden (UNAIDS, 2014).

HIV/AIDS is a chronic disease that increases medical, social and economic burden on individuals, family and communities (WHO, 2005). However, early identification and enrolment of HIV infected patients into treatment programs play a critical role in reducing this burden. HIV Testing and Counseling (HTC) provides the opportunity to identify infected persons and is the gateway into HIV prevention, care and support, and treatment services, including Prevention of Mother to Child Transmission (PMTCT) of HIV (FMOH 2014). It provides an opportunity for people to learn about HIV/AIDS, know their sero-status and cope with the outcome of their test results (USAID, 2014).

Literature review

Nigeria, the most populous country in Africa, is estimated to have a population of about 170 million people (UNIDO, 2014), with HIV prevalence of 3.4% (FMOH 2013) in the general population making it one of the countries with the highest burden of the disease in Sub-Saharan Africa (Souleymane et al, 2006). Like in other low and middle income countries (LMIC), despite the serious challenge that HIV poses, progress towards universal coverage of HTC services has remained inadequate (WHO 2012a).

Even though the absolute numbers of individuals who were counselled, tested and given results in Nigeria more than doubled between 2012 and 2013, and the numbers of HTC sites increased by 34% from 2009-2013; only 23.5% of male and 29.2% of female reported ever testing for HIV in 2012 (NACA, 2014a).

Nigeria has explored various models for the delivery of HIV counselling and testing in an attempt to improve access to HTC. In the early stages of the national HIV response, access to HTC services was limited to health facilities where health care providers requested for HIV testing based on high index of suspicion (clinical and behavioral). Following this, HTC was then expanded to stand-alone and Heart-to-Heart centers which offered voluntary counseling and testing to members of the community in addition to hospital-based HTC. A variant of hospital-based HTC later emerged which emphasized Provider Initiated Testing and Counseling (PITC). This focused initially on all pregnant women attending antenatal care clinics within the health facility with the option to opt out.

While PITC has generally been shown to increase access to HIV testing with reasonable positivity yield, it has not helped to achieve universal coverage of HIV counseling and testing (Hensen et al, 2012; Baggaley et al, 2012). The barriers that have been reported include wrong public perception of HIV as a tool for only diagnosis, low risk perception in the population, stigma and inability to reach subgroups in the population who do not routinely access hospital services (NACA 2014a; Matovu 2007). This brought to the fore the need to “expand community based options and innovations to reach the population beyond the health facility” (WHO, 2012b) in order to reach sub-populations who will not routinely seek care in the hospitals and so unlikely to benefit from hospital based HTC.

In line with National Prevention policy (NACA, 2014b) and the move towards universal access in Nigeria, AIDS Prevention Initiative in Nigeria (APIN) with support from the Global Fund for community-based outreaches in its 3 states of operation in Nigeria to emphasize the need for a strategic mix of hospital based and community based approaches to HTC. The objectives of the community-based outreaches conducted were:

1. To scale up HTC services to the general population and pregnant women within the community
2. To promote early identification and referral for early care and treatment of HIV infected persons within the community

Methodology/Approach

The community based HCT services in this reported activity is an intervention to improve access to HCT services towards scaling up universal access, supporting people to know their HIV status outside the routine hospital facility settings and provide linkage and access to further care and treatment for identified positive cases.

APIN, in conjunction with Civil Society Organizations (CSOs) and health care workers in specific Local Government Areas (LGAs) across three (3) states of Nigeria (Lagos, Oyo and Plateau states), carried out community based HTC outreaches over a period of 3 weeks. These community based outreaches was conducted with funding support from the Global Fund (GF) and National Agency for the Control of AIDS (NACA). It focused on testing people not previously reached with HTC services in the preceding 6 months and pregnant women receiving ANC services in informal settings such as Traditional Birth Centers (TBC) and Faith Based Centers (FBC) within the communities. It also emphasized messages about HIV/AIDS, care and treatment opportunities and improved linkage and referral of HIV positive patients to health facilities.

Geographical location selection and determination of coverage

The following factors were considered in deciding the location for these activities:

- a) The available prevalence structure of HIV in the state, LGA with high burden and high populations were selected for these activities.

- b) Previous epidemiological survey about high-risk populations and their distributions within the state and the LGA was also considered.
- c) Antenatal attendance records and population estimates of the possible number of pregnant women were also considered to help in deciding locations for HCT for pregnant women.
- d) Availability of HIV care and treatment facilities to receive newly diagnosed cases with minimal need for long travels.

The above four factors were used to ensure that the exercise has the best impact and yield for such community based campaign.

Community engagement and stakeholder sensitization

The next step in the process was partnership with CSOs who had capacity and strong presence within communities in Lagos, Oyo and Plateau states. A one-day sensitization meeting with CSOs was held where the methodology for the outreach and proposed coverage were agreed. CSOs were linked to Global Fund-supported treatment facilities to facilitate collaboration and effective referrals. Rapid Test Kits (RTKs), consumables, data collection tools and targets to be reached in each LGA were distributed to the CSOs.

Advocacy and sensitization

Advocacy and sensitization visits were made to community stakeholders and gatekeepers by the CSOs to solicit their support and participation in mobilizing their community members. Letters of introduction and notice of HTC for general population and pregnant women were sent to chairmen of the respective LGAs, Local AIDS Control Agency (LACA) Managers, Medical Officer of Health (MOHs), community heads, National Union of Road Transport Workers (NURTW), churches (FBCs), mosques, schools, market associations and TBCs. This was followed by sensitization visits to further engage with key gatekeepers within the LGAs where the communities to be targeted were discussed and agreed on. The various gatekeepers mobilized their communities to participate in the exercise.

Mobilization drives within selected communities were carried out through the use of town criers, condom distribution, talk show, use of indigenous dance and drama groups and musicians Rallies were also staged in tertiary institutions, market places and motorcycle and taxi/bus parks. House-to-house campaigns to improve participation were also employed in some communities.

HIV testing and counselling

HTC was provided to the general population at motor parks and under tents at strategic places within the community. Volunteer counsellors collaborated with Birth Attendants (BAs) at TBCs and FBCs to provide HTC for pregnant women in line with National guidelines. Referral for family Planning services, sexually transmitted infection (STI) screening, and linkage to treatment facilities for additional care and treatment were integrated into the HTC services.

Health care workers from designated GF-supported treatment facilities also facilitated client referral. Identified HIV positive clients among the general population and pregnant women were referred using the client referral forms with the option of being accompanied to the facility by a support group member.

Ethical approval

Data used for this analysis was collected as part of routine data from program implementation. This was approved for exemption by the National Health Research Ethics Committee of Nigeria (NHREC), with NHREC approval number: NHREC/01/01/2007-15/05/2013.

Data collection and analysis

Data was collected using the National data collection forms and registers for HTC and PMTCT during the implementation of the outreach. The HTC client intake form provided the counsellors a checklist guide for pre-test and post-test counseling, and documenting HIV test results for each client. In addition to the counselling, the form included HIV knowledge assessment, HIV risk assessment as well as symptomatic screening for Tuberculosis and sexually transmitted infections. Data from the client intake forms were summarized into the HTC register for the general population or PMTCT testing register for the pregnant women.

HIV positive clients were referred to the treatment facilities for enrollment into HIV care using the client referral form. Data from these were summarized into the referral registers.

Data was further summarized by LGA for the general population and pregnant women using a summary form which was designed for the purpose of the community-based outreach. Data analysis was performed using simple excel functions to develop cross-tabulations that allowed from comparison across states.

Results

Outreaches for HTC in the general population were conducted in 47 communities across 6 LGAs in Lagos state; 56 communities across 5 LGAs in Oyo state and 86 communities in 7 LGAs in Plateau state. 47 ANC locations (which included 38 TBCs and 9 FBCs) in Lagos state; 79 ANC locations (which included 42 TBCs, 25 FBCs and 12 maternity homes) in Oyo state and 28 ANC locations (all TBCs) in Plateau state conducted HTC for pregnant women.

Table 1. Summary of results from community based outreach

State	LGAs	HTC Communities (General Population)	ANC Locations	HTC (General population)	Number Positive (Positivity rate)	HTC (Pregnant Women)	Number Positive (Positivity rate)
Lagos	6	47	47	18,177	47 (0.26)%	9,007	17 (0.19%)
Oyo	5	56	79	18,189	36 (0.2%)	12,068	4 (0.03%)
Plateau	7	86	28	18,675	72 (0.38%)	14,989	15 (0.1%)
Total	18	189	154	55,041	155 (0.28%)	36,064	36 (0.1%)

The outreaches witnessed strong community support as some communities provided comfortable space for HTC and free accommodation for volunteers that worked in hard to reach areas during the period of the outreach.

As in table 1, during the outreaches across the three states, 55,041 adults within the general population were provided with HTC, while 36,064 pregnant women were counseled and tested for HIV.

Of the 54,841 adults tested within the general population, 155 persons were identified as HIV positive, giving a positivity rate of 0.28% while a total of 36 pregnant women were identified as HIV positive out of the 36,061 pregnant women tested, giving a positivity rate of 0.1%.

With regards to complete referral, 131 (84%) HIV positive clients among the general population and 26 (72%) HIV positive pregnant women were completely linked to GF-supported treatment facilities. Most of the gaps in referral were in Plateau state where 14 HIV infected clients among the general population and one (1) pregnant women were already receiving HIV care at some other facilities but still went ahead to receive HTC. The remaining HIV infected clients were still in denial at the time of referral and refused to access HIV care. These were followed up within the community to make sure that they accessed HIV care.

Discussion

Over time, HTC was voluntary and mostly facility based, and access required some welfare loss to transportation cost. This community based outreach removed structural, logistic and social barriers by taking services to the community (WHO 2012b) to reach persons who may not ordinarily access healthcare in a health facility. All commodities for HTC were available at points closest to the homes and HTC was delivered by trained volunteers. According to WHO and UNAIDS, community based HTC can increase knowledge of HIV within the community (11) (WHO, 2012b). Structured messages about HIV, its transmission and prevention, and availability of care and treatment to HIV infected community members were included during the counselling sessions.

Partnership with civil society organizations that have strong presence within the communities and collaboration with health care providers was found to improve community participation and uptake of the services. Without doubt, partnership and collaboration are very important strategies for improving population health (Shortell et al, 2002), which succeed most when mutual understanding of the goal, rules of engagement, coverage and strategies exist (14) (Centre for Disease Control). The CSOs that were engaged have long standing relationships implementing various programs with the communities and thus, are key stakeholders who are seen as leaders within the communities.

The results of the three week community based approach for HTC increased access and uptake of HTC when compared with facility based reports for HTC from the treatment facilities between January 2014 to December 2014 in the same communities (19,344 clients in the general population were provided HTC; 13,093 pregnant women received HTC). The outreach also served as a screening program for early identification of HIV infections in the various communities.

Focusing on the results of HTC among pregnant women during this outreach further illuminates the need for continuous programming for PMTCT to include HTC at informal ANC settings. Our observation was that, there were many TBCs and FBCs around treatment facilities and deep within the communities. It thus appears that the communities had greater trust in the TBCs and FBCs which make them very important structures and further create barriers to facility based ANC (Sibley, 2007). HIV positivity rates in TBC and FBCs in the community based outreach was 0.1% which can translate into the proportion of HIV exposed infants that would be delivered to these communities. There is, therefore an urgent need to actively include these informal ANC settings as part of programs to eliminate mother to child transmission of HIV (eMTCT). This will, however, raise questions about the ethical and legislative considerations for full implementation of eMTCT to include dispensing of anti-retroviral drugs at these informal settings.

Comparing HIV positivity rate in facility based HTC and this community based HTC, we observed lower HIV positivity rate in community based HTC. Reports of HTC from the treatment facilities by state from January 2014 to December 2014 was 9% in Oyo and Plateau states and 11% in Lagos state among the general population; and 1.6% Oyo state, 2%, in Plateau state and 1.9% in Lagos state among pregnant women. HIV positivity rate was calculated as 'Number of new HIV infections' divided by 'Number of individuals that received HTC multiplied by 100. Similar observation of lower HIV positivity rate in community based HTC was made by Suthar et al after reviewing 14 studies (Suthar et al, 2013).

Notwithstanding, early identification of these clients and structured post-test counseling focused on behavior change will likely reduce the spread of HIV infection within these communities (NACA, 2014b). Earlier diagnosis of HIV and immediate linkage of clients to HIV treatment centers to commence HIV care and treatment will sustain the productivity of the client (FMOH, 2014), reduce the likelihood for early HIV related morbidities and mortalities (Bradley et al, 2014) and fewer children will become orphans. HIV positive pregnant women, who would have carried an HIV exposed baby to term unknowingly, were linked to the treatment facilities where they were provided with triple anti-retroviral therapy to prevent mother to child transmission of HIV. This will also reduce the chances of birthing an HIV infected child and the attendant socio-economic challenges to the families.

Recommendations

1. Outreach campaigns are effective ways of rapidly scaling up HCT services and it has the capacity to improve universal access and coverage for HCT services.
2. For outreaches to be successful, careful planning, adequate community mobilization and participation, stakeholder's engagement and adequate logistic support for the exercise are key considerations that must be addressed in detail.
3. Non-financial incentives and behavioral change communication messages will help improve HCT service uptakes during outreach campaigns. Effective referral support and immediate linkage to care and treatment programs must be readily available to further support newly identified cases to take up treatment for their disease.
4. Programming around eMTCT can be expanded to include informal ANC settings

Conclusion

Alternative approaches to facility based HTC is critical to achieving universal access to HTC. Community based approach to HTC that relies on strong partnerships and collaboration with organizations that have commitments and leadership roles in the communities can improve uptake of services. It is a veritable approach for expanding access, availability and coverage of HTC services. Ultimately, new HIV infections are identified and linked immediately to treatment facilities for HIV care and treatment. Community Based HTC with strong partnership base is recommended for scale up of services in resource limited settings like Nigeria.

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