atlas
Stronger when you know
Promoting access to HIV self-testing in West Africa
SENEGAL – CÔTE D'IVOIRE – MALI

World Health Organization

The 10 essentials for HIVST implementation and scale up

HIV epidemic in West and Central Africa is mixed with a low to moderate prevalence in the general population and a high prevalence in specific subgroups (including KP). Despite increases in testing coverage, large numbers of key population (KP) and vulnerable groups are hard-to-reach (i.e. occasional FSW and not self-identified MSM). These groups are less likely to access HIV testing and to seek care due to socio-cultural, political, and sometimes legal stigma.

Distribution of new infections in the region demonstrates that beyond KP, representing 42% of new infections, **their social networks (clients, partners) are also playing a significant role in the dynamic representing 27% of the new infections[1]. Other groups, difficult to reach or reluctant to access HIV testing facilities are also considered at higher risk of HIV, for example, partners of PlwHIV or STI patients and their partners.**

Recognising the global challenge to reach the first 95, WHO recommends since December 2016 the introduction of HIV Self-testing (HIVST) in HIV national testing strategies as an empowering, discreet and highly acceptable approach. To introduce and implement successfully HIVST, **it is important to consider HIVST integrated and complementary to other strategies within national differentiated testing strategy in a focused way that prioritizes areas and populations with the greatest gaps in testing coverage[2].**

HIVST can be distributed through various models/delivery channels and shall be considered depending on the local context and community preferences such as community based, facility based, online, secondary distribution, pharmacies, workplaces. Particularly to facilitate social networks of PlwHIV or KP to HIVST, **secondary distribution represents a key strategy to be considered.**

It is also crucial to empower and effectively engage communities in developing, implementing and adapting HIVST delivery and support models.

National programs are encouraged to define a minimum package to support users on HIVST use and to promote linkage to services. This can be regularly reviewed and adjusted as programs expand and scale up. **Linkage to appropriate services after HIVST is critical to achieve its full benefits even though users' confidentiality and willingness to notify their results shall be respected.**

Additionally, countries and programs shall monitor and evaluate their HIVST implementation. Systematic data collection/report for HIVST distribution is mandatory to monitor program implementation. **However systematic data collection on HIVST use and results is not recommended** (but voluntary feedback from users can be collected for analysis) nor realistic (i.e: secondary distribution). Therefore, data triangulation shall be considered to effectively monitor and evaluate HIVST outcomes and indirect impact.

Lastly, **it is important to develop specific HIVST standard operating procedures**. These should ensure clear description of tailored delivery strategies and models but also integrate recommendations for registration and availability of quality-assured HIVST products or propose minimum quality standards for training and demand creation.

It is also important before moving towards full HIVST scale up to consider a short pilot implementation phase (4-6 months) to experiment HIVST delivery models in real context. Lessons learning from this phase will help countries to consolidate tailored national SOPs, strategies and tools based.

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[1]UNAIDS data book 2020: https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pdf
[2]WHO guide for planning, introducing and scaling up HIVST
https://apps.who.int/iris/bitstream/handle/10665/275521/9789241514859-eng.pdf

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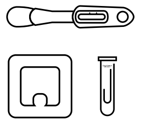

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Key activities/steps to introduce and scale up HIVST

Design & Preparation phase (6-8 months)

- Conduct **situational analysis** for HIVST introduction
- Define **HIVST distribution models** based on existing HTS strategies, gaps and existing programs
- Perform **HIVST quantification and procure kits**
- Define **HIVST indicators and supervision tools**
- Develop appropriate and innovative **linkage strategies and user's supporting tools**
- Develop **HIVST creation demand strategy and tools**
- Develop **training curricula/tools**
- **Register quality HIVST** in the country

Testing phase (4-6 months)

- Train first batch of dispensing agents
- Implement **HIVST test phase in a limited number of sites**
- **Supervise & evaluate to adapt HIVST strategies**
- **Adapt/revise SOPs, training curricula, supporting tools based on lessons learned**

Progressive scale up phase

- **Develop and validate HIVST national strategy/guidelines**
- Develop progressive **scale up plan**
- Implement scale up plan **with regular supervision ensuring full integration of HIVST in national HIS and PSM systems**
- Adapt/**revise HIVST quantification based on 6 months/1 year** scale up phase
- Consider private sector model for general pop° access to HIVST

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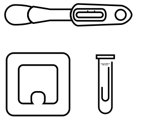

10 key elements to check for HIVST implementation and scale up

Financial resources are secured to:

☐ Conduct a **situational analysis involving community and civil society stakeholders and define with civil society stakeholders and community HIVST SOPs/guidelines** (including delivery models and strategies, regulation on quality products, minimum standard for training and demand creation, supporting tools for user's, M&E indicators…)

☐ **Develop HIVST training curricula** adapted to specific HIVST delivery models and dispensing agents **and conduct training of national trainers/all training for dispensing agents** in facilities and communities where HIVST will be distributed

☐ **Develop and make available HIVST supporting tools** for users and to promote linkage to confirmation and care (i.e.: leaflets, digital tools demonstration video, free HIV hotline…)?

☐ **Procure** WHO PQ/GFATM ERPD approved **HIVST kits consistently with quantification needs/gaps**

☐ **Evaluate pilot phase** if any (to adapt strategies, training and supporting tools) **and supervise regularly HIVST implementation** (ideally integrated in HIV supervision)

☐ **Develop and validate HIVST national strategy/guidelines**

Scale objective / HIVST quantification method

☐ **HIVST scale and quantification are consistent with country capacity to implement HIVST activities** (national registration done, implementing partners/services available, HIVST integrated in prevention and testing programs, linkage to care available)

☐ **HIVST quantification** is based on **delivery models defined including secondary distribution/social network approach**

HIS and M&E system

☐ **HIVST key indicators and supervisions are integrated within HIS national system** to allow key indicators data collection, report and evaluation

☐ **M&E indicators are in line with WHO recommendations and respect confidentiality of users** (one mandatory indicator: HIVST distribution with disaggregation, no direct/systematic indicator on HIVST use and results)

For more information : https://atlas.solthis.org

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