HIVST Monitoring & Evaluation: lessons learnt from West and Central Africa

The 28th April 2022 – 3.00 pm to 4.15 pm CEST

Inscriptions : https://who.zoom.us/webinar/register/WN_PKANXUtFRpmk2k7Ek0Przw

Webinar organized by the World Health Organization, the ATLAS project and the STAR initiative, in partnership with Unitaid.

This webinar proposes to discuss different approaches to HIVST monitoring and evaluation based on the ATLAS project and the STAR Initiative experiences in West and Central Africa.

01 **Introduction**
Rachel Baggaley, WHO

02 **HIVST M&E WHO guidance**
Anne Bekelynck, WHO

03 **ATLAS Project M&E approaches**
Anthony Vautier, Solthis

Focus on data triangulation method
Arlette Simo Fotso, IRD

04 **Digital platforms : experience from the STAR initiative**
Karin Hatzold, STAR, PSI

05 **The Senegalese experience**
Dr Fatou Fall, DLSI

06 **Ivorian community actor testimony**
ATLAS project video

07 **HIVST M&E Global Fund approach**
David Maman, Global Fund

08 **Discussion with panelists**
Chaired by Naye Bah

Bienvenue - Nous allons commencer à 13h(GMT)/15h(CEST)

Welcome – We will start at 1pm (GMT)/ 3pm (CEST)

Suivi & évaluation de l'autodépistage du VIH en Afrique de l'Ouest et du Centre

Le 28 avril 2022 – 13h – 14h15 GMT

Inscriptions : https://who.zoom.us/webinar/register/WN_PKANXUtFRpmk2k7Ek0Przw

Webinaire organisé par l'Organisation Mondiale de la Santé, le projet ATLAS, l'initiative STAR, en partenariat avec Unitaid.

Ce webinaire propose d'aborder différentes approches de suivi & évaluation de l'ADVIH basées notamment sur l'expérience du projet ATLAS et de l'initiative STAR en Afrique de l'Ouest et du Centre.

01 **Introduction**
Rachel Baggaley, OMS

02 **Présentation des orientations de l'OMS sur le S&E de l'ADVIH**
Anne Bekelynck, OMS

03 **Approches de S&E du projet ATLAS**
Anthony Vautier, ATLAS, Solthis

Focus sur la triangulation
Arlette Simo Fotso, ATLAS, IRD

04 **Plateformes digitales : expériences de l'initiative STAR**
Karin Hatzold, STAR, PSI

05 **Retour d'expérience du Sénégal**
Dr Fatou Fall, DLSI, Sénégal

06 **Témoignage d'un acteur communautaire de Côte d'Ivoire**
Capsule vidéo du projet ATLAS

07 **Approches du S&E de l'ADVIH du Fonds Mondial**
David Maman, Fonds Mondial

08 **Discussion avec les panélistes**
Présidé par Dr Nayé Bah, OMS

La session est en français avec une interprétation simultanée en anglais.

HIVST Monitoring & Evaluation: lessons learnt from West and Central Africa

- Agenda:

Moderator: **Mach-Houd Kouton, UNAIDS**

Session Title	Speaker	Time
Welcome and introductions	Rachel Baggaley, WHO	5 min
HIVST M&E WHO guidance	Anne Bekelynck, WHO	10 min
M&E approaches and tools from the ATLAS project **The data triangulation method**	Anthony Vautier, Solthis/ATLAS Arlette Simo Fotso, IRD/ATLAS	15 min
Digital platforms to facilitate HIV Self-testing and reporting through the client journey, experience from the STAR Initiative	Karin Hatzold, PSI/STAR	10 min
Experiences from HIVST M&E in Senegal	Fatou Fall, DLSI	10 min
Global Fund HIVST M&E approaches	Obinna Onyekwena, GF	10 min
Discussion with Panellists	Chaired by Nayé Bah, WHO	15 min
Total		75 min

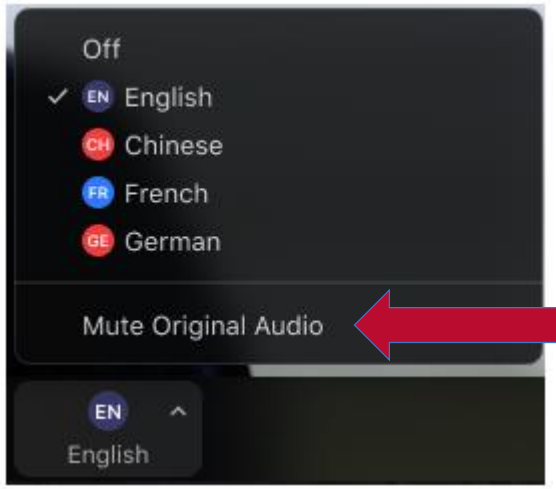
- Agenda:

Moderateur: **Mach-Houd Kouton, UNAIDS**

Titre de la session	Présentateur	Durée
Bienvenue et introduction	Rachel Baggaley, OMS	5 min
Orientations de l'OMS sur le suivi & évaluation de l'ADVIH	Anne Bekelynck, OMS	10 min
Approches de S&E du projet ATLAS **La méthode de la triangulation des données**	Anthony Vautier, Solthis/ATLAS Arlette Simo Fotso, IRD/ATLAS	15 min
Plateformes numériques pour faciliter l'ADVIH et son suivi tout au long du parcours du client : l'expérience de l'initiative STAR.	Karin Hatzold, PSI/STAR	10 min
Retour d'expérience du Sénégal	Fatou Fall, DLSI	10 min
Approches du S&E de l'ADVIH du Fonds Mondial	Obinna Onyekwena, FM	10 min
Discussion avec les panélistes	Présidé par Nayé Bah, OMS	15 min
Total		75 min

Housekeeping

How to join audio interpretation line



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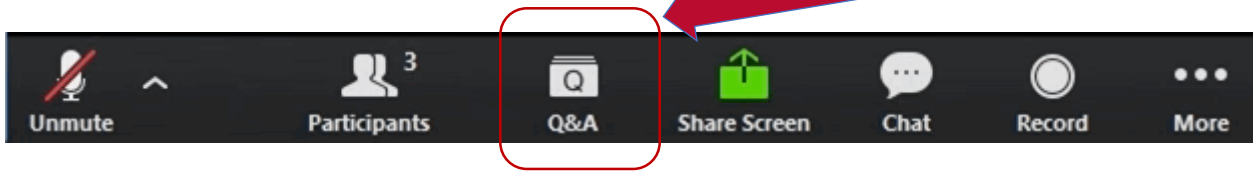
Choose to mute the original audio or listen to both, translation will be louder than speaker



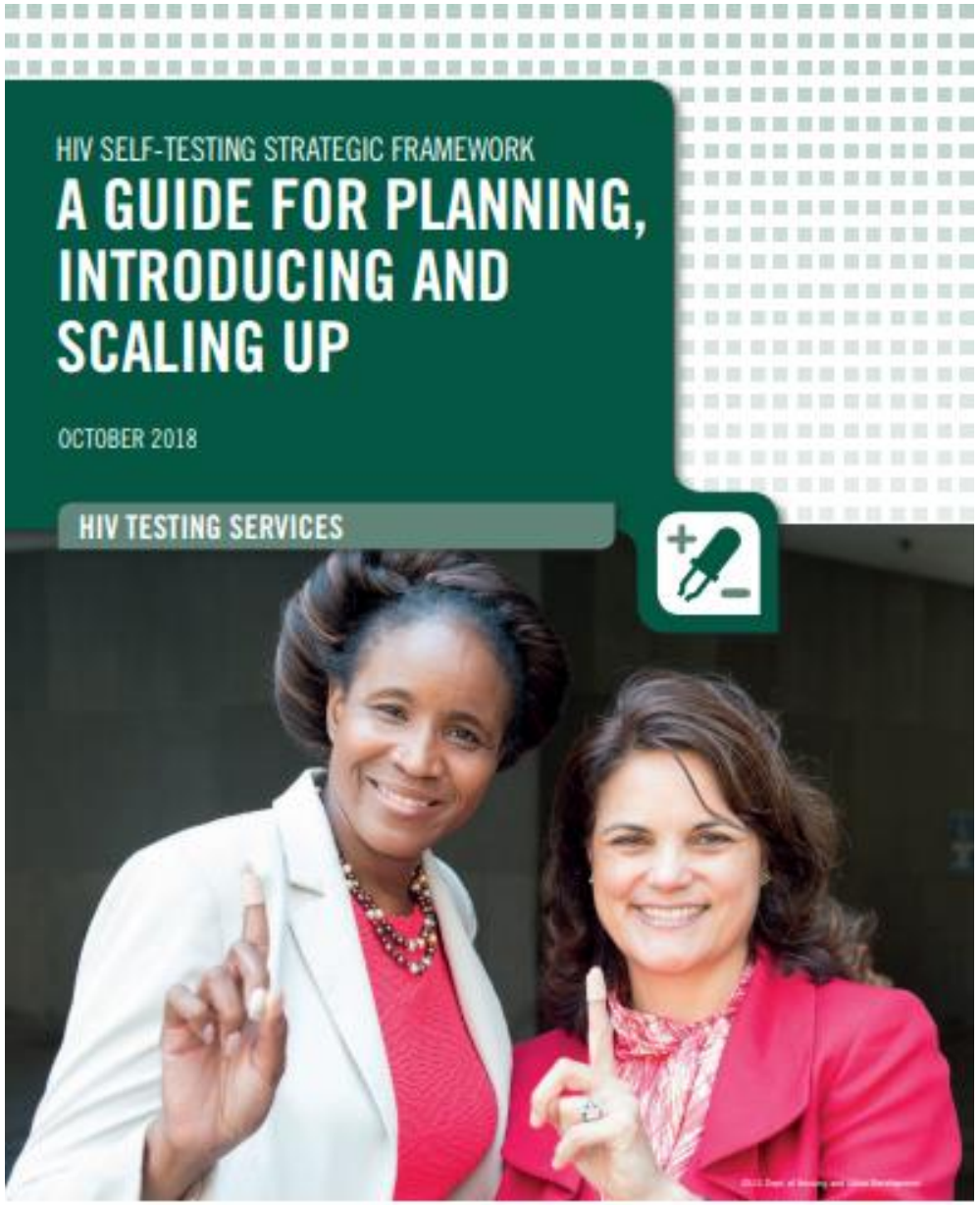
Chat; Q&A and support

- Presentation slides and recording link will be shared by email for those who registered after the session
- This session is being recorded and your attendance is consent to be recorded.
- Please use the Q&A function icon to ask questions, not chat

HIVST M&E : Introduction

Webinar WHO/ATLAS/STAR, HIVST M&E, 28 April 2022

- ***Dr Rachel Baggaley,*** *WHO Global HIV, Hepatitis and STIs Programme*



HIV self-testing monitoring and evaluation

Principles

Anne Bekelynck, Muhammad Shahid Jamil, Céline Lastrucci, Magdalena Barr-Dichiara, Cheryl Johnson, Rachel Baggaley

28 April 2022 – WHO/ATLAS/STAR webinar

WHO HTS: *https://bit.ly/2RQiW4M*
HTS Info on the Go: *https://apple.co/2LAB8vt*
WHO HTS Data Dashboards: *http://hts.hivci.org/*

Self-testing policy timeline and way forward

1st HIVST kit discussed

1986

2008

FDA

First HIVST kit under review by FDA

2005

FDA

2011

2012

2014

2015 – 3 countries with policies and 1 HIVST product

2013

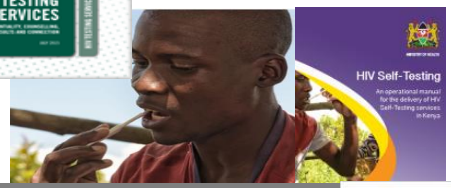
1st International Meeting on HIVST

WHO review on HIVST in health workers

HIVST comes to Europe: 2 products CE marked and on sale in UK and France

Unitaid STAR project kick-off Zimbabwe November 2015

2015



1st WHO PQed kit & real world implementation

2016

2017

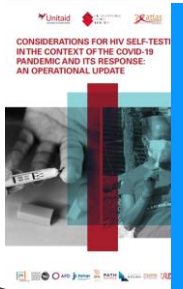
WHO Self-Care and Updated HIVST guidelines on optimized service delivery

WHO recommends HIVST

WHO HIVST Scale-up guide

2018

HIVST as a key COVID adaptation

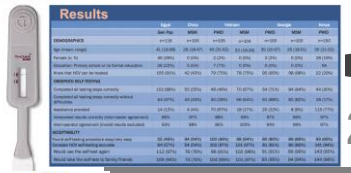


93 countries with policies.
4 PQ HIVST kits
Price $1.50-3.09
Market size: >10 million;
21 million confirmed in 2021-23 procurement + new Global Fund Strategic Initiatives

2019

2020

Unitaid approves 3ACP – C19 ST Proposal Brazil, India, Malawi, South Africa, Zimbabwe



2021

Self-care studies for HCV (WHO & FIND)
WHO HCVST guidance July 2021

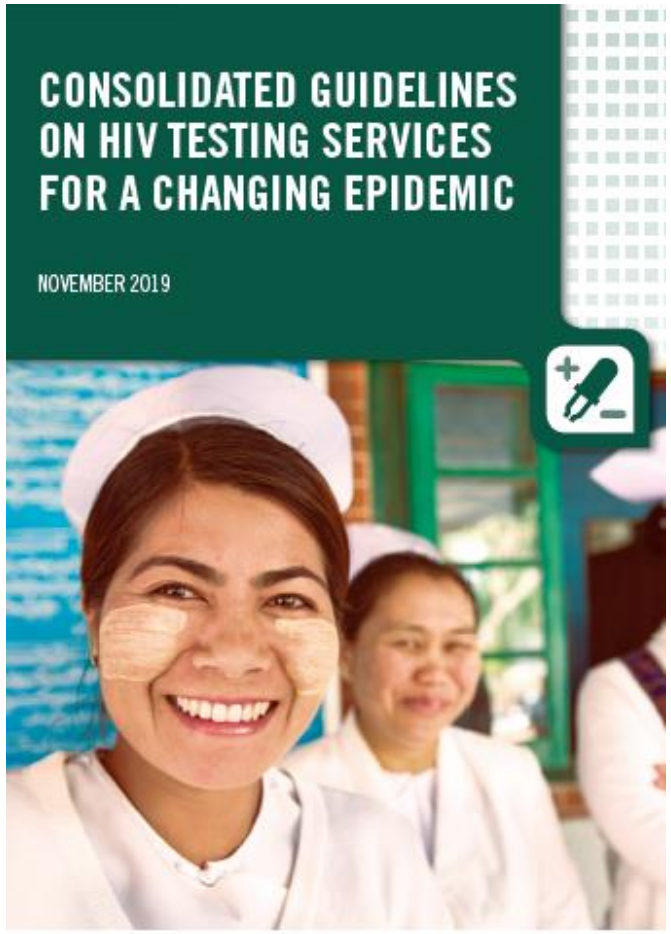
Scale-up of self-testing for broader self-care across HIV, STI, HCV, COVID-19 and beyond

IAS 2021 18–21 July

World Health Organization

New WHO guidelines on HTS for a changing epidemic (2019)

8 updates and new recommendations/guidance



Box. 1 Summary of new WHO guidance, recommendations and good practice statements

1. **Demand creation:** NEW **Good practice statement** highlighting evidence-based approaches and considerations for the use of incentives for HIV testing services, including linkage.
2. **Counselling message:** ✓ **Updated** messages and guidance on concise communications with emphasis on linkage and latest information on the benefits of treatment and prevention services.
3. **HIV self-testing:** ✓ **Updated** HIV self-testing should be offered as an approach to HIV testing services *(strong recommendation, moderate-quality evidence)*.
4. **Social network-based approaches:** NEW Social network-based approaches can be offered as an HIV testing approach for key populations as part of a comprehensive package of care and prevention *(conditional recommendation, very low-quality evidence)*.
5. **HIV testing strategies:** ✓ **Updated.** In response to changes in the HIV epidemic, WHO encourages countries to move toward using three consecutive reactive tests to provide an HIV-positive diagnosis.
6. **Western blotting:** NEW Western blotting and line immunoassays should not be used in national HIV testing strategies and algorithms *(strong recommendation, low-quality evidence)*.
7. **Dual HIV/syphilis rapid diagnostic tests:** All pregnant women should be tested for HIV, syphilis and hepatitis B surface antigen (HBsAg) at least once and as early as possible *(syphilis testing: strong recommendation, moderate-quality evidence; HBsAg: strong recommendation, low-quality evidence)*.

   NEW Dual HIV/syphilis rapid diagnostic tests (RDTs) can be the first test in HIV testing strategies and algorithms in ANC settings.
8. **Optimal maternal retesting time points:** ✓ **Updated.** In high HIV burden settings, retesting is advised for all pregnant women with an unknown or HIV-negative status during late pregnancy (third trimester). Catch-up testing is needed if the first test or retest is missed or delayed. High HIV burden countries could consider an additional retest in the post-partum period for specific districts or regions with high HIV burden or incidence, women from key populations or who have a partner with HIV who is not virally suppressed.

WHO recommendations on HIV self-testing (2019)

Source: WHO 2019

Key evidence showed HIVST is:

- Safe and accurate
- Highly acceptable
- Increased access
- Increased uptake and frequency of **HIV testing among those at high risk and who may not test otherwise**
- Comparable linkage and HIV+
- Empowering
- Can be affordable and cost-effective when focused

WHO recommendation:

HIV self-testing should be offered <u>as an approach</u> to HIV testing services

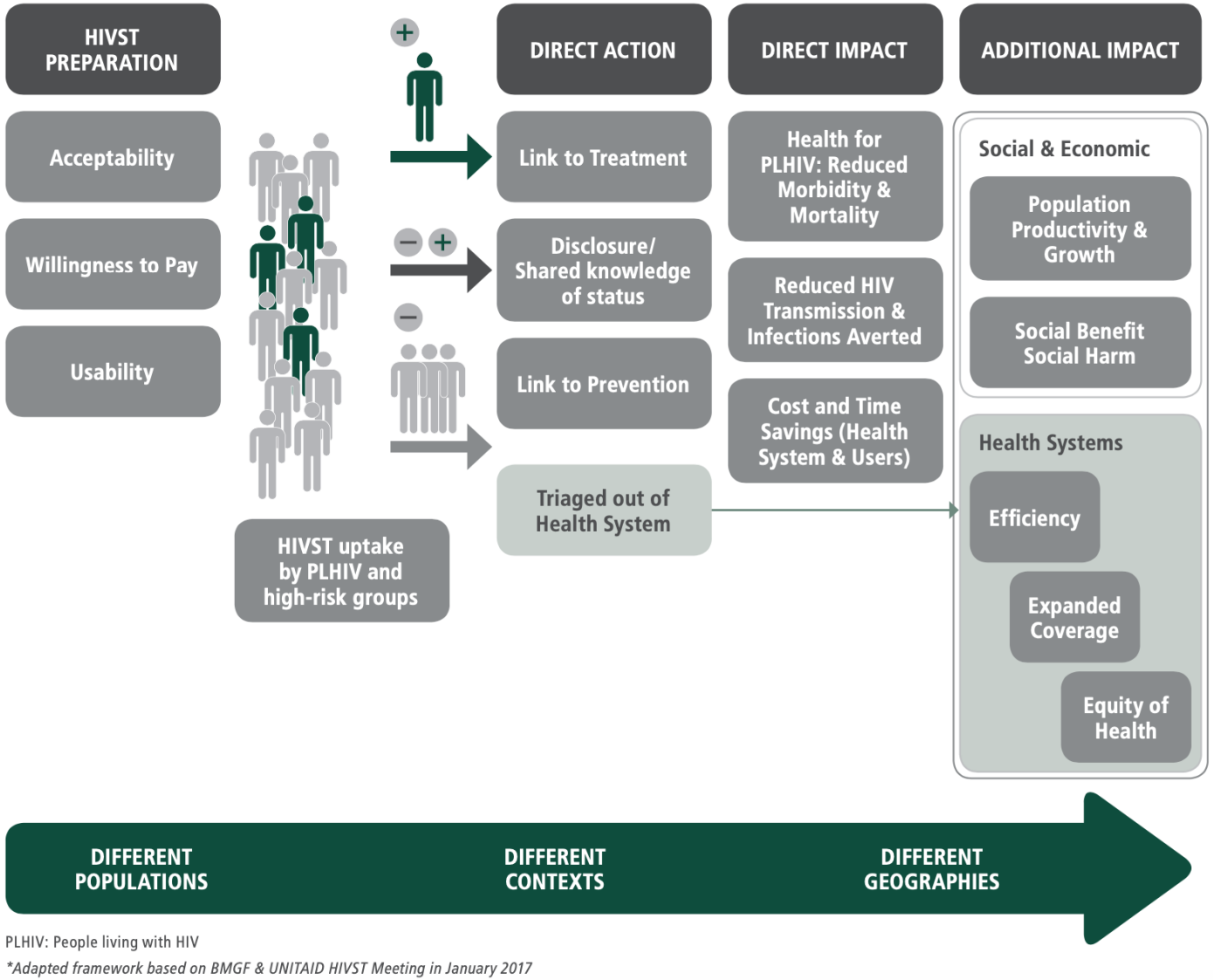
(strong recommendation, moderate quality evidence)

Remarks

- Providing HIVST service delivery and support options is desirable.
- Communities need to be engaged in developing and adapting HIVST models.
- HIVST does not provide a definitive HIV-positive diagnosis. Individuals with a reactive test result must receive further testing from a trained tester using the national testing algorithm.

IMPACT FRAMEWORK FOR HIVST

FIG. 4. IMPACT FRAMEWORK FOR HIVST

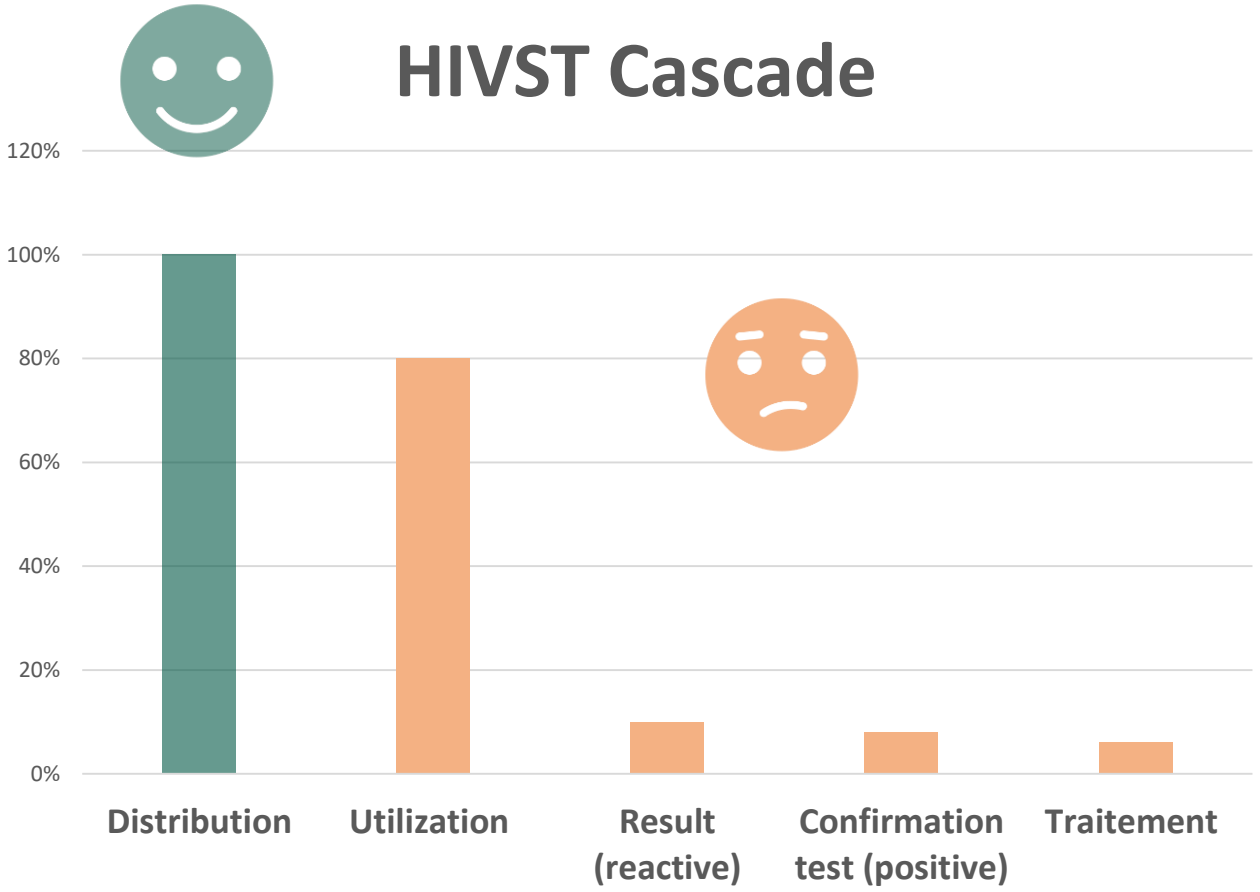


PLHIV: People living with HIV

**Adapted framework based on BMGF & UNITAID HIVST Meeting in January 2017*

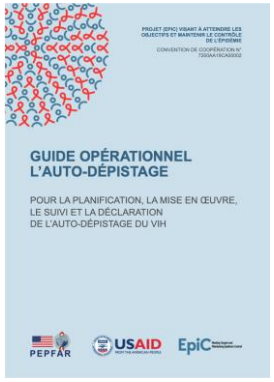
M&E HIVST CHALLENGES

- Privacy of the test & autonomy of users
- More difficult to know the results and linkage to treatment/prevention services
- High cost and difficult feasibility of an individual follow up at the national program level



GENERAL PRINCIPLES

A compilation of various indicators & tools being used by programmes for HIVST monitoring



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HIV SELF-TESTING
AFRICA
INITIATIVE

- Using **multiple data sources** and information (including triangulation)
- Data collection **should not be intrusive** or burdensome ; protection of confidentiality and privacy
- **Human and financial cost** of active monitoring to be considered
- Prioritization on the use of
  - **Routine data (=integration & sustainability)**
  - **Triangulation (= impact at the population level)**

KEY DATA SOURCES FOR HIVST M&E

Routine programme monitoring

Routine HIVST monitoring	Self-reported data on HIVST	Data on use of HIVST from other service data	Special surveys, population size data, client/patient based surveys
HIVST service register, HIVST order form, sale registers	Self-administered forms, client feedback, hotline follow up calls	ART/PrEP service register, HTS register, health statistics	Target groups for HIVST. Group size. Coverage of HIVST.
HIVST kits distributed. People receiving HIVST. Coverage of HIVST programme.	People reported on using HIVST results. Reported results positivity yield.	People reported on using HIVST services prior to confirmatory HIV test, ART, PrEP, etc.	Group using HIVST. Positive yield of HIVST.
	People reported on using services after HIVST. Accessing confirmatory test, ART, PrEP, etc.		Percentage accessing confirmatory test, ART, PrEP, etc.

EXAMPLES OF ROUTINE HIVST MONITORING TOOLS USED DURING KITS DISTRIBUTION

Individual level data

Site level data

Provider or self-administered assessment form	**Individual HIVST register** (provider administered) Existing services register add-on	Individual HIVST form (client self-administered) Client referral card	**HIVST online order** and assessment form	Event register or site level commodity register	Online or retail Sale register

Information on people receiving HIVST

Information on HIVST model and approach

Number and type of HIVST kits distributed

EXAMPLES OF ROUTINE HIVST MONITORING TOOLS USED FOR COLLECTING DATA ON TEST USE AND RESULTS

Notification/reminders

- Automated SMS and messengers reminders
- Interactive voice response systems

Client self-administered reporting

- Paper based on-site results reporting cards
- Mobile apps, messengers, chat bots, website results reporting and feedback collection forms

Individual-level follow up

- Provider administered individual follow up and feedback forms, referral cards

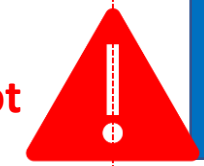
considerations for resources and sustainability + note intrusive

- Number of HIVST tests used
- Number of HIVST results reported, number of positive results reported
- Information on people using HIVST and reporting it

EXAMPLES OF ROUTINE HIVST MONITORING TOOLS USED FOR COLLECTING DATA ON LINKAGE

Notifications and referrals	Self-administered reporting	Individual-level follow up	Clinic registers
Referral cards to link to services. Automated SMS and messages. Interactive voice response systems	Mobile apps, messengers, chat bots, web apps and online feedback collection forms	Provider administered individual follow up forms, peer referral and navigation	HTS registers, **ART registers**, PrEP registers, etc.

considerations for resources and sustainability + not intrusive



Number of people self-reported positive tests results confirmed after HIVST

Number of people self-reported link to prevention and treatment services after HIVST

Proportion of people using prevention, testing and care services prompted by HIVST

M&E INDICATORS RELATED TO HIVST

Distribution	Use and results	Linkage
• **Number of individual HIVST kits distributed (programme data) (required)** • Number of sites distributing HIVST kits (programme data) • Percentage of first time testers among people who received HIVST (programme data) • Percentage of the population aware of HIVST (survey) • Percentage of the population willing to self-test if available (survey)	• Number of HIVST tests used and the percentage of HIVST-positive results observed and self-reported (programme data) • % of the population who has ever self-tested (survey) • % of the population who has ever self-tested and reported positive result of self-test (survey) • % of those tested in the last 12 months reporting self-test as their last test (survey)	• Number and percentage of people diagnosed with HIV following HIVST (programme data) • Percentage of new ART initiations among people diagnosed with HIV who report prior self-testing in the past 12 months (programme data) • Proportion of people who test positive for HIV using an HIVST, enrolled in ART services (survey) • Percentage of PrEP initiations among people who report prior self-testing in the past 12 months (survey)

TAKE AWAY

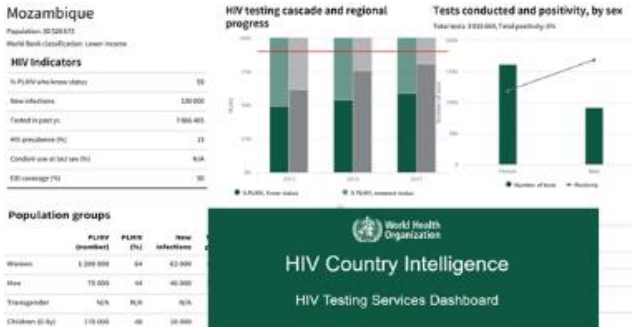
- **Individual follow-up** to collect information on utilization, result, and linkage to treatment **is hardly feasible** on a national program scale

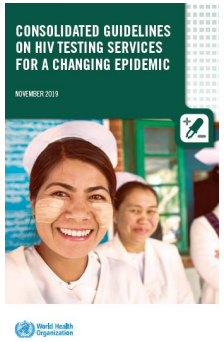
- Not all of the proposed indicators/monitoring tools are possible to implement in all contexts: important to adopt a **pragmatic approach**, based on sustainability and integration

= Focus on routine data + the data triangulation method developped by ATLAS

Access the full guidelines on the WHO HTS APP!

- Search ‘WHO HTS Info’ wherever you get Apps
- Notifications when new content is available
- Search, save, send
- Country HTS data in one place w/ guidelines
- Language updates: French on the way!
- Available online and off
- Videos coming for 2020





ATLAS M&E Approaches and data triangulation

Anthony Vautier, Directeur technique du Projet ATLAS, Solthis

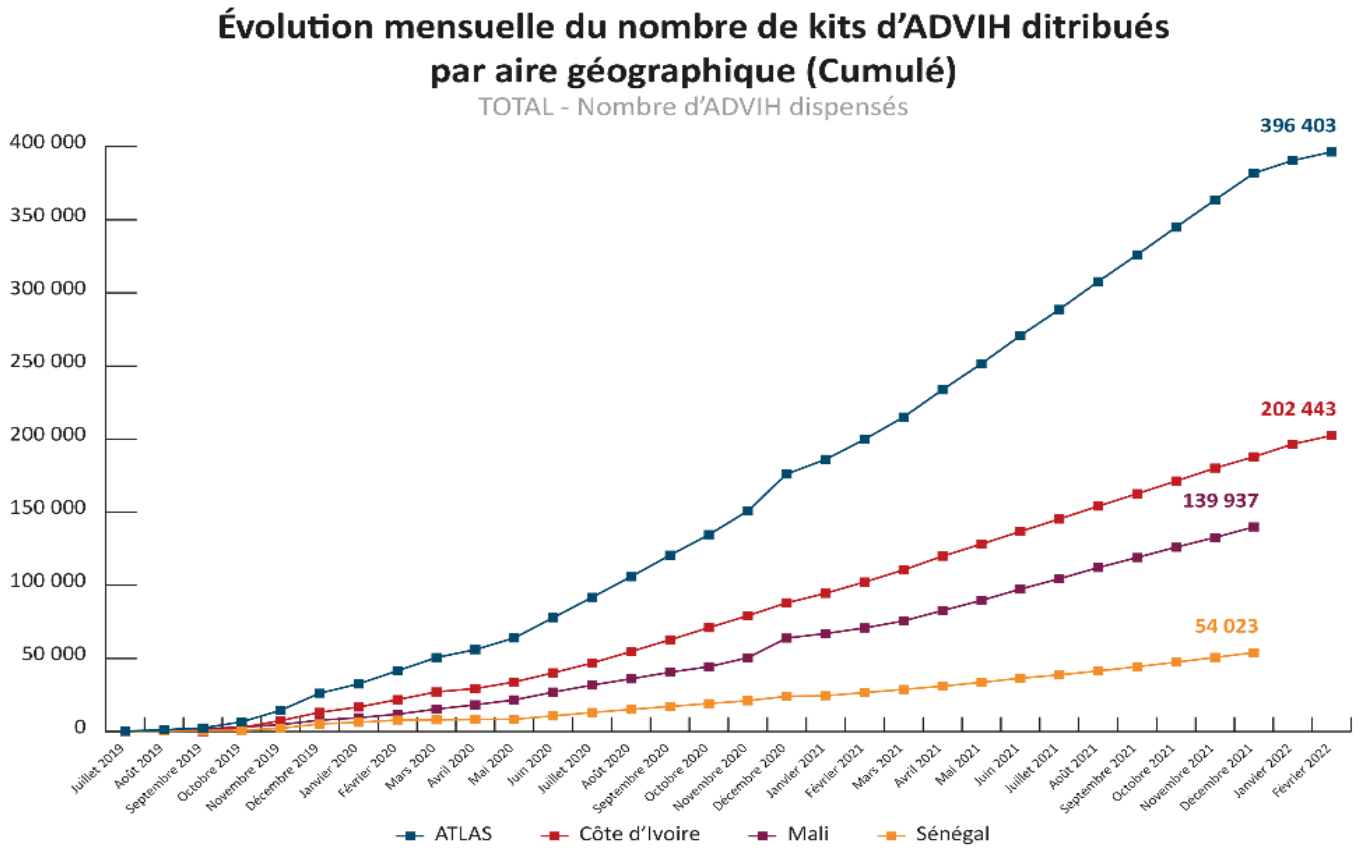
Arlette Simo Fotso, Démographe & Économiste, IRD/CEPED

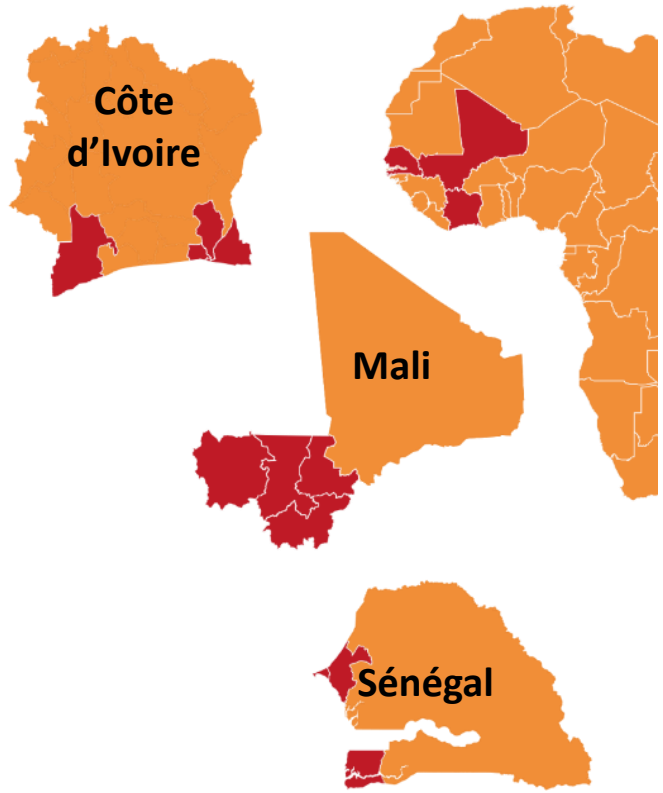
HIVST MONITORING & EVALUATION: LESSONS LEARNT FROM WEST AND CENTRAL AFRICA

28 avril 2022

- Coordinated by **Solthis in consortium with IRD**
- Implemented with > **30 partners**
- Budget **15 millions USD** funded par **Unitaid** (additional funds from **AFD)**

- **3 countries, 13 régions**
- **Almost 400 000 kits** distributed
- **+ 200 distribution sites**
- **4 years** (mid-2018 / mid-2022)





ATLAS : Strategies and priorities for distribution

Primary distribution

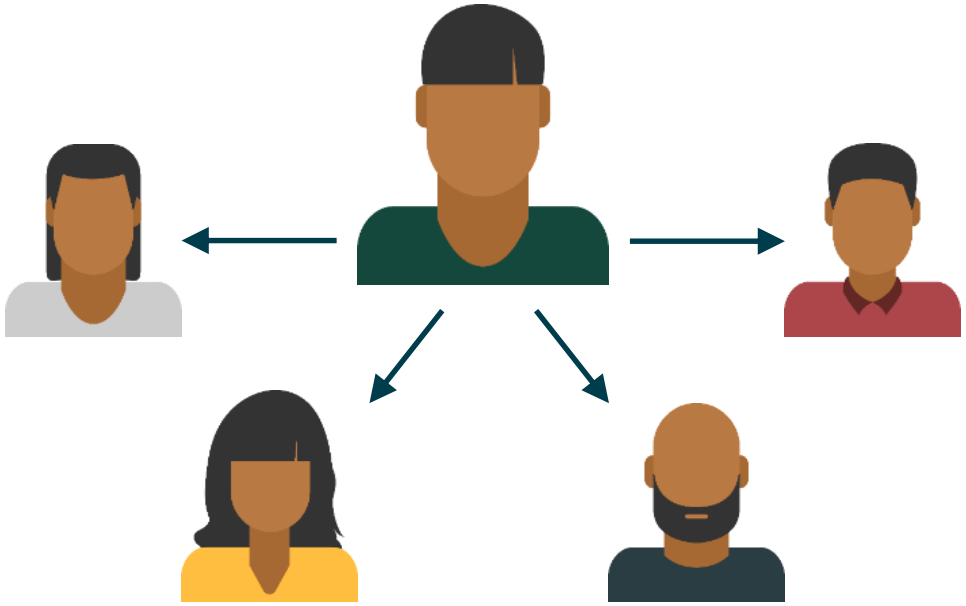
Supporting tools for distribution*:

Demonstration video in 7 languages, IFU, additional leaflet, free hotline, website

https://atlas.solthis.org

YouTube Projet Atlas

Secondary distribution to peers, partners & clients



8 delivery channels (KP, Index case, partners of STI patients)

90% of distribution through KP delivery channels

Focus on secondary distribution > beyond KP /social network

85 % of distribution through community based activities

ATLAS : Research for evaluation and integrated M&E system

Impact model

Impact evaluation

Include user's experience and linkage to care

Qualitative WP

Social factors and impact
KP, index cases and STI

Phone survey

End users profile and linkage to confirmation/ care

Costing WP

Coût / Efficacité
Objectif de mise à l'échelle

Data collection performance & impact

Comparison with testing and ART initiation

ATLAS districts / non ATLAS Districts

Data Triangulation with national routine data available

DHIS2

HIVST distribution / desegregated data

Qualitative data

HIVST Results, linkage to confirmation/care

Regular FGD with dispensing agents
Health workers, peer educators

***In* 2021, spontaneous feed back data collection (quantitative – 7% sample)**

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M&E approach and routine data collection

No systematic, mandatory and proactive tracking on HIVST use and results (feasibility for secondary distribution (logistic, cost), confidentiality and ethic)

BUT systematic support/follow up proposed to users > +/- effective depending on delivery channels and contexts

Bias on data collected at confirmation level (under reported/KP) > Data Collection and analysis of spontaneous feedback even though results have to be interpreted cautiously

Qualitative data collection (FGD) and analyses informative and useful

t n ty t t n ton t n
t o n y

Paradigm change…

- **Some peers not confortable without systematicresults follow up**
- **Delegation of power to users (self care) not easy at the beginning**
- **Potential reluctance due to other performance indicators /HIV testing (including financial motivation**

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AutoTest VIH, Libre d'Accéder à la connaissance de son Statut
SÉNÉGAL - CÔTE D'IVOIRE - MALI

Using routine programmatic data to estimate the population-level impacts of HIV self-testing: the example of the ATLAS program in Côte d'Ivoire and Senegal

Institut de Recherche pour le Développement
FRANCE

Solthis
Solidarité Thérapeutique et Initiatives pour la Santé

Introduction

Rationale of the study

- HIVST is an innovative tool that empowers individuals and ensures confidentiality

- WHO recommends reporting on number of HIVST kits distributed and estimating HIVST access and use through population-based surveys.
  - This could be costly and add additional burdens for countries

- To assess their impact, some programs have developed tracking methods to verify HIVST use and result.
  - However, such tracking can be costly, and logistically challenging, especially for secondary distribution
  - counterproductive and limit HIVST use and distribution as it is not in line with HIVST philosophy – where users can decide when and where being tested and if and to whom they want to report their result.

Objectives

- Though, without systematic and direct feedback or survey regarding the use and results of HIVST and linkage to confirmatory testing and ART, it is challenging to estimate the impacts of HIVST distribution

- **Objective**: To use routinely collected programmatic data to estimate and assess indirectly the effects of ATLAS' HIVST distribution in Côte d'Ivoire.

Method

Data

- ATLAS project monitoring and evaluation data from Q3-2019: number of HIVST distributed by ATLAS

- Surveillance data from Pepfar (President's Emergency Plan For AIDS Relief) for CIV : conventional testing, positive tests, ART initiations and number of HIVST distributed by Pepfar
  - publically available on https://data.pepfar.gov/

- DLSI (Ministry of Health, Prevention and Public Hygiene of the Republic of Senegal - AIDS Division) data for Senegal

⇒ Adults 15 years +

⇒ All aggregated at the level of 78 health districts (CIV) and 77(Senegal)

⇒Time period : Q3 2019 – Q1 2021

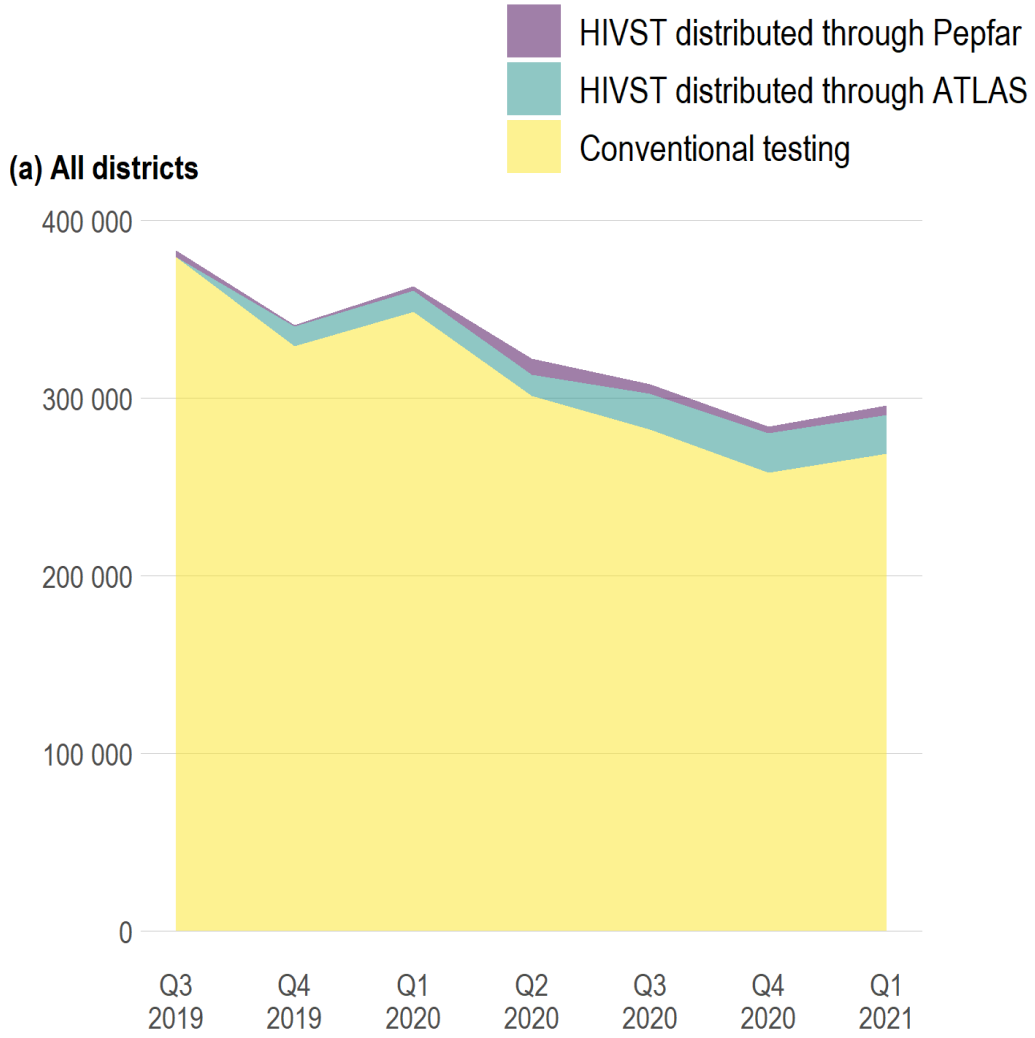
Analysis strategy

- **Ecological time series regression**
  - Period from Q3-2019 to Q1-2021 (with quarterly observations) 78 (77) health districts
  - A district-level random-effects model was used to account for the autocorrelation of observations
  - The trend was modeled by a categorical variable of time (trimester)
- **Variable of interest**: the number of HIVST distributed through ATLAS activities
- **Dependent variables**:
  - Access to HIV testing assuming HIVST utilisation rate (UR) of 80% = conventional testing + 80% of HIVST distributed by ATLAS and Pepfar
  - Access to HIV testing UR 60% = conventional testing + 60% of HIVST distributed by ATLAS and Pepfar
  - Conventional testing : the number of individuals tested for HIV who received results (i.e. self-testing excluded)
  - HIV diagnosis : number individuals newly tested positive for HIV
  - ART initiations : the number people newly enrolled on ART

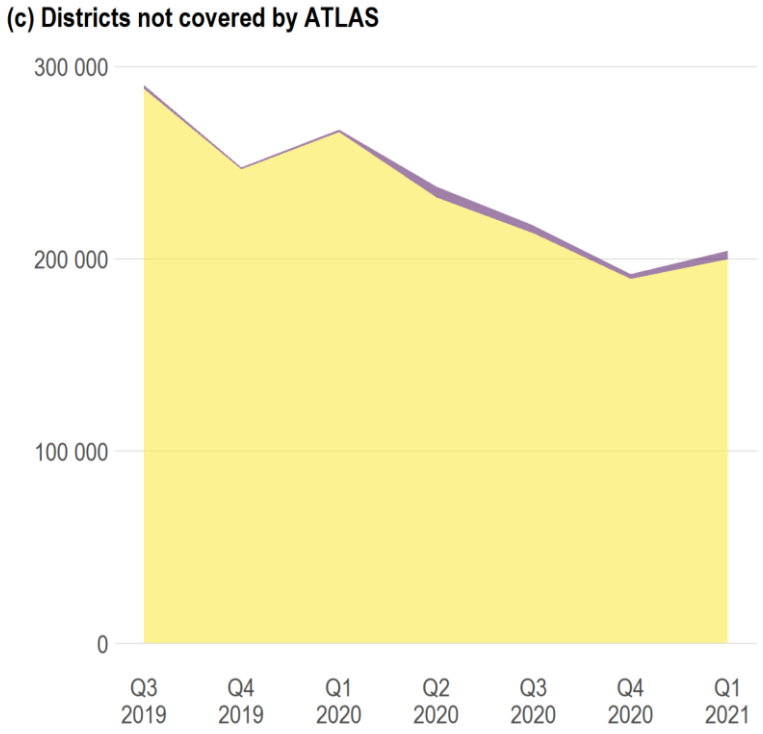
Results

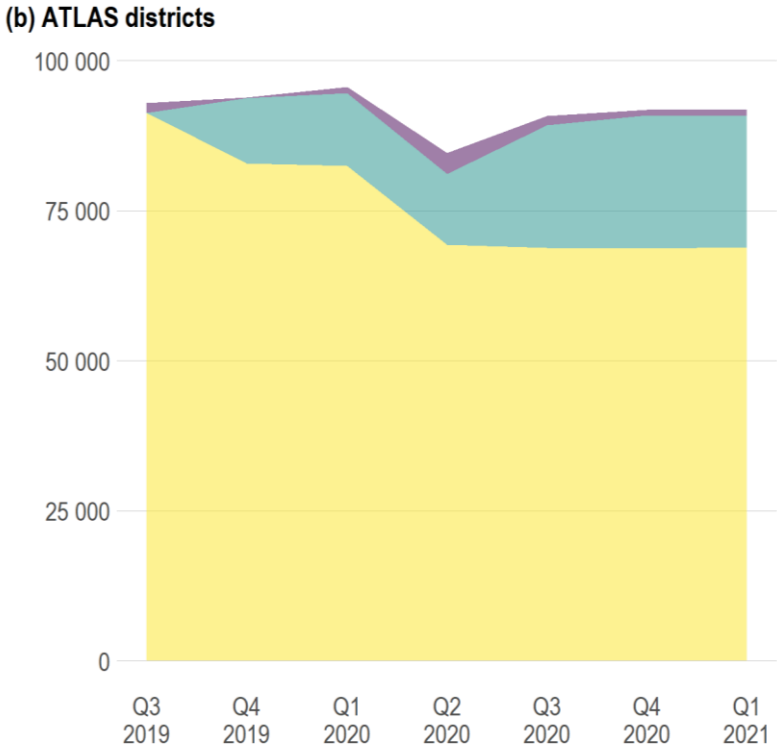
The number of HIVST distributed by ATLAS increased continuously since the beginning of dispensation in Q3 2019 in Côte d'Ivoire

- Between Q3 2019 and Q1 2021, 99 353 HIVST kits were distributed through ATLAS
- 30 781 HIVTS kits were distributed through PEPFAR,
- compared with 2 245 908 conventional tests performed over the same period
- conventional testing decreased overall, with 379 554 individuals tested for HIV who received their results in Q3 2019 vs. 268 807 in Q1 2021

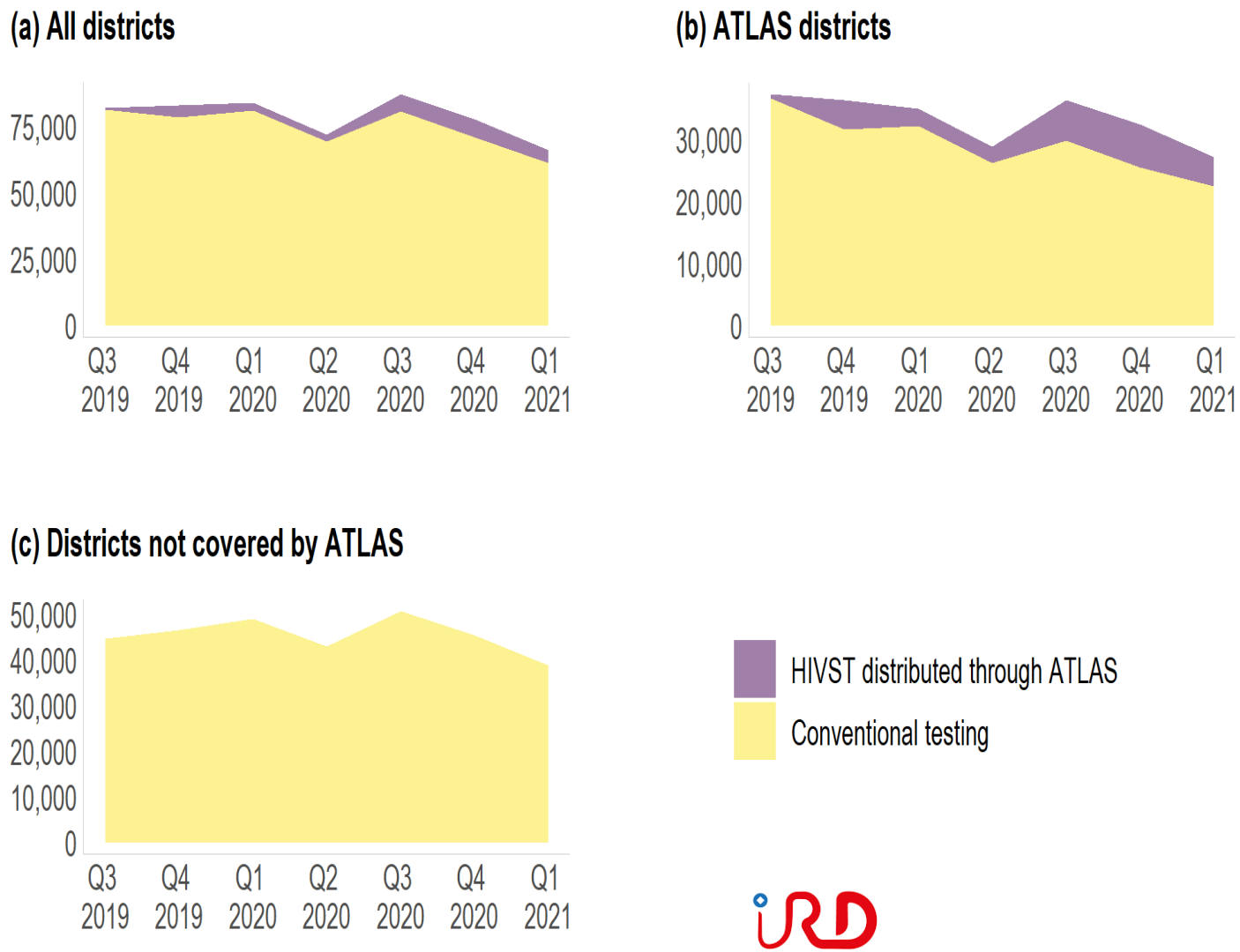


In districts not covered by ATLAS (figure c), HIVST kits distributed through PEPFAR remained limited and largely insufficient to compensate the reduction of conventional testing in Côte d'Ivoire





Similar trend observed in Senegal



Effect of the number of HIVST distributed by ATLAS in Côte d'Ivoire

- For 1000 additional HIVST distributed through ATLAS during a quarter in a district, **589 additional individuals** would have accessed HIV testing under the 80% UR hypothesis,
- And **393** under the 60% UR hypothesis.
- ATLAS HIVST distribution had a negative but non-significant effect on conventional testing
- For 1000 additional HIVST distributed through ATLAS it resulted in **8 additional diagnosis**
- Non-significant effect observed on ART initiation
- Sensitivity analyses modelling time with cubic spline instead of categorical variables showed almost similar results overall

	Adjusted for time and region		
Outcome	Beta	95% CI[1]	p-value
HIV testing (HIVST UR: 80%)	**0·589**	**0·356 to 0·821**	**<0·001**
HIV testing (HIVST UR: 60%)	**0·393**	**0·160 to 0·625**	**<0·001**
Conventional testing	-0·195	-0·427 to 0·038	0·10
HIV diagnosis	**0·008**	**0·000 to 0·015**	**0·044**
ART initiations	-0·002	-0·008 to 0·005	0·66

Effect of the number of HIVST distributed by ATLAS in Senegal

- For 1000 additional HIVST distributed through ATLAS during a quarter in a district, **453 additional individuals** would have accessed HIV testing under the 80% UR hypothesis,
- ATLAS HIVST distribution had a negative but non-significant effect on conventional testing
- For 1000 additional HIVST distributed through ATLAS it resulted in **53 additional diagnosis**
- And **17 additional ART initiation**

	Adjusted for time and region		
Outcome	Beta	95% CI[1]	p-value
HIV testing (HIVST UR: 80%)	**0.453**	**-0.032 to 0.938**	**0·068**
HIV testing (HIVST UR: 60%)	0.253	-0.232 to 0.738	0·31
Conventional testing	-0.347	-0.832 to 0.138	0·16
HIV diagnosis	**0.053**	**0.031 to 0.074**	**<0·001**
ART initiations	**0.017**	**0.009 to 0.025**	**<0·001**

Limits of the study

- Ecological bias: information is aggregated at the health district level
- Power issue: some non-significance could be due the low number of observations
- Collected data do not allow to distinguish between confirmatory tests following an HIVST and classic conventional tests.
- We do not have detailed information of HIVST distributed by UNICEF or global fund (though the volumes of distributed kits by these programs were very low) in CIV
- PEPFAR datasets are not exhaustive in Côte d'Ivoire and cover only 78 out of 113 health districts during our study period

Conclusion

- First study to assess the effect of HIVST at the population level in West Africa, which has a unique epidemic context
- A strength of this study is that it uses only indicators routinely collected by countries and do not rely on any systematic tracking system or data collection process.
- Our analysis showed a positive effect of the number of HIVST distributed by ATLAS on HIV testing and diagnosis.
- By allowing programs to shift from systematic tracking for evaluation, such indirect evaluation would help to focus on increasing access to HIV testing for hard to reach population and first time testers and allow large scale secondary distribution implementation.
- This would allow progress towards the UNAIDS 95-95-95 targets to end HIV / AIDS by 2030

Variables needed to replicate these analyses

- number of HIVST distributed
- Number of conventional testing,
- Number of new diagnostic/ positive tests,
- Number of new ART initiations

⇒ Adults 15 years +

⇒ All aggregated at the level of health districts

⇒And per trimester

THANK YOU FOR YOUR ATTENTION

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Solidarité Thérapeutique et Initiatives pour la Santé

IRD
Institut de Recherche pour le Développement
FRANCE

STAR
SELF TESTING

Digital platforms to facilitate HIV Self-Testing and reporting through the client journey

Experiences from the STAR Initiative

Karin Hatzold, Project Director STAR

Unitaid
Innovation in Global Health

psi

STAR HIVST kit distribution May 2016-March 2022, 13 countries (N=5,198,690)

HIV Self-Testing Client Journey

Attract	Access	Use	Link to Care/ Prevention
How clients learn about HIVST kits, and why they initially found the kits to be either appealing or unappealing, risk-perception and value proposition.	How easy or difficult it may be to access HIVST kits, which includes: stigma; availability, ability to obtain/purchase HIVST kits.	Factors associated with using HIVST kits, administering the test, reading/interpreting results, and offering test to partner.	Client's awareness and ability to link to confirmative testing, treatment care or preventive services

Unassisted HIV Self-Testing

ENABLERS AND BARRIERS ALONG THE HIVST CLIENT JOURNEY

Enablers

Attract	Access	Use	Link to Care/Prevention
Convenience	Wide range of access points	Provider Interaction	Informational Materials
Anonymity	Close to clients	Informational Materials	Free Treatment
Confidentiality			

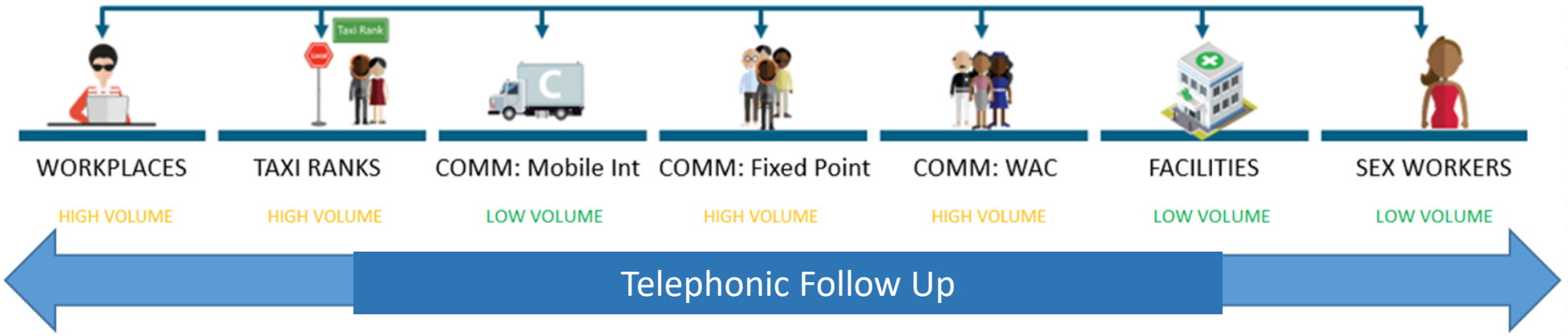
Barriers

Attract	Access	Use	Link to Care/Prevention
Stigma	Price	Difficulties understanding instructions	Norms Around Masculinity
Suspicion	Perceived lack of Anonymity and Privacy	Self-Efficacy	Health Centers
Lack of Awareness	Knowledge of where to access self – test kits	Mistrust in the validity of test result	Lack of Support Tools
Risk-Perception			Lack of Support from Distributors
Mistrust in the validity of test			

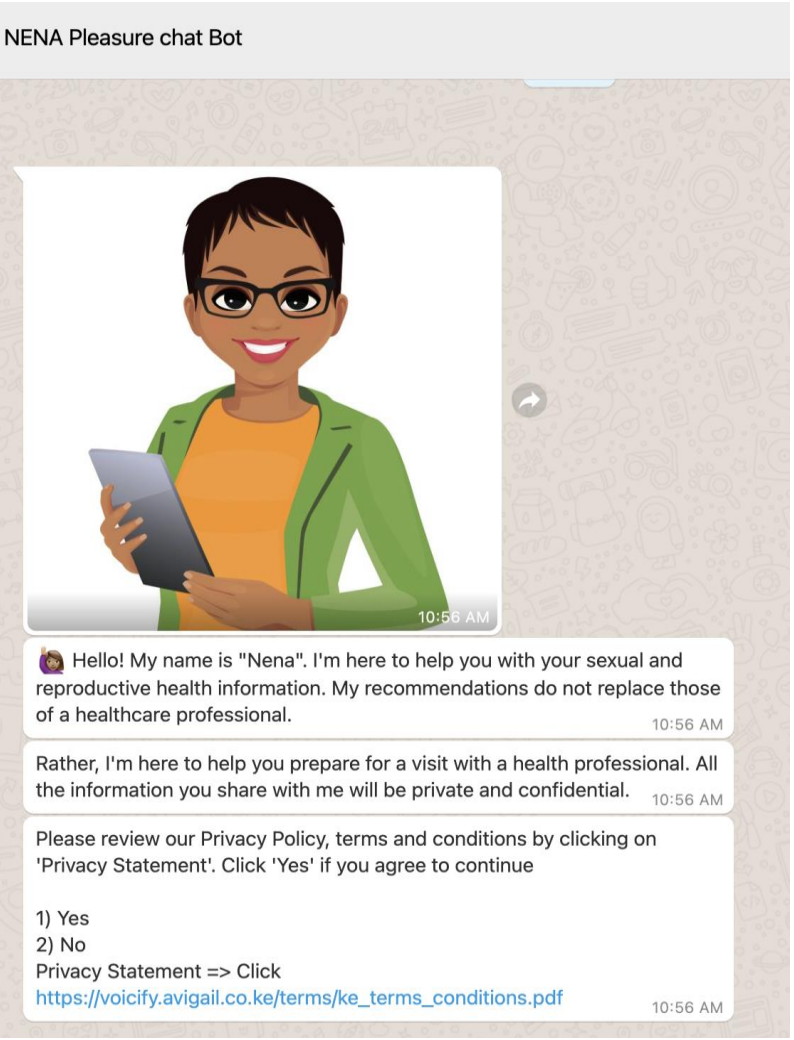
The Challenge…

How do we increase awareness and promote HIVST as a tool that provides confidentiality, de-stigmatization, and empowerment…. And balance it out with the need for assistance to conduct the test, interpret the result and to create a space for the user to make the right choice, unassisted, to act upon their result and access post –test services.

STAR transition to digital strategy



HIVST Chatbot App



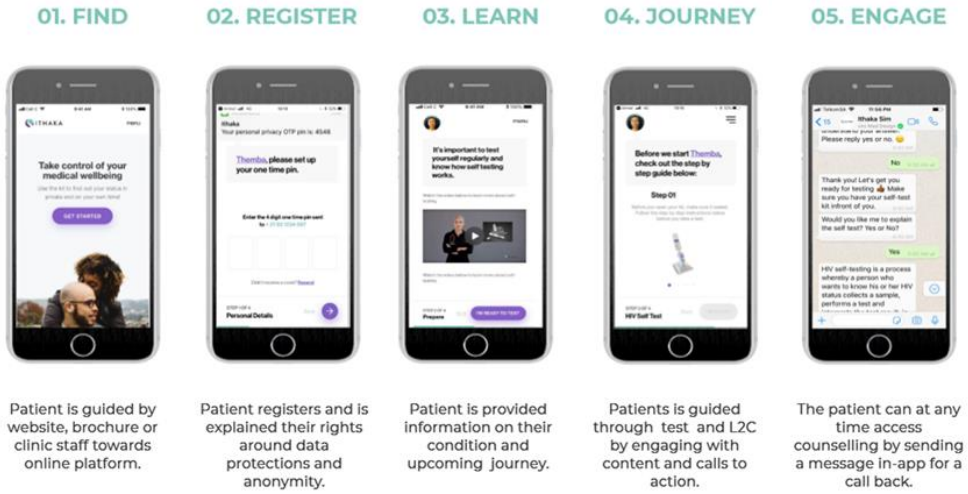
Simulate conversation via text-based algorithms

- Find a kit/Signposting
- E-Vouchers
- Private access to curated information
- Screening
- Feedback loop with human
- Automated follow-ups and reminders
- Data Collection

Chatbot Architecture:

- **User facing interface**: WhatsApp, FaceBook Messenger, website, USSD, Twitter, Telegram, web-based microsites etc.
- **Conversation Logic**: Dialogflow or RapidPro
- **Data storage**: MongoDB or DHIS2
- **Analytics:** DHIS2, PowerBI, Google Analytics, more

HIVST Chatbot Flow



Chatbot Entry Point 1: user learns about Chatbot from marketing efforts. Demand creation through social media campaigns, sign-posting to access test kit, e-voucher

Chatbot Entry Point 2: user receives a self test kit from a distribution point and is guided to the chatbot by the IEC materials.

HIVST is accessed by user

User accesses chatbot to guide them through the use of the self-test

User self tests and reports results

User is guided through options for post-test services referral voucher

User accesses post-test services

User confirms their linkage to care/prevention and outcome in the chatbot

# of chatbot users/profile

# of HIVST users/test kit

# of users reporting results

# of self-reported access to care/ prevention

Data push of key indicators from Chatbot backend to a front-end analytics tool PBI or DHIS2

dhis2

Power BI

HIVST Chatbot South Africa Pilot

- **Find a kit**
  - Information on online, pharmacy, and health facility options
  - Locations or websites to find a kit based on the users' preference and location
- **HIV Self-Testing guidance**
  - Videos, pictures, and written instructions for OraQuick, INSTI, and Mylan test kit use
- **Help**
  - At any time, a user can enter "help" and see a list of national hotlines for support
- **FAQs**
  - Links to the test kits FAQ pdf documents

- Client profile
  - Sex, province of residence, HIV testing history
  - Number of self reported HIV risk factors
- Self reporting
  - Kit use & results
  - Confirmatory testing results
  - ART uptake
- Content consumption

  Able to track content clients are accessing in the Chatbot

HIVST Chatbot South Africa Data Dashboards

ZA HIVST_# of clients reporting Yes to HIVST use by Test Kit used in each province by Age/Gender_This Year

2021 - T_South Africa_D2A - in 1																																										
	ZA HIVST Age	1-4 Years			5-9 Years			10-14 Years			15-19 years			20-24 Years			25-29 Years			30-34 Years			35-39 Years			40-44 Years			45-49 Years			50+ Years			Total
ZA HIVSS Type of kit used	ZA HIVST Province / ZA HIVST Gender	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	
INSTI	Eastern Cape																											1		1										1
	KwaZulu-Natal															1	1																							1
																1	1											1		1										2
ORAQUICK	Eastern Cape																	1		1	2																			2
	Free State										1			1																											1
											1			1				1		1	2																			3
MYLAN	Eastern Cape																					1			1															1
	Gauteng																													1			1							1
																						1			1					1			1							2
Total											1			1			1	1		1	2	1			1		1		1	1			1							7

ZA HIVST_# of clients reporting positive in each province by Age/Gender_This Year

2021 - T_South Africa_D2A - Positive																																										
ZA HIVST Age	1-4 Years			5-9 Years			10-14 Years			15-19 years			20-24 Years			25-29 Years			30-34 Years			35-39 Years			40-44 Years			45-49 Years			50+ Years			Total
ZA HIVST Province / ZA HIVST Gender	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	
Eastern Cape																	1		1	2	1			1		1		1											4
Gauteng																													1			1							1
KwaZulu-Natal															1	1																							1
Total															1	1	1		1	2	1			1		1		1	1			1							6

Qualitative Data

HIV Knowledge and Testing Experience

♂

- High level of awareness about HIV transmission, HTS, treatment, prevention, low level of knowledge about PrEP, but high interest
- Scared of positive results, but regular testers
- High preference for HIVST

♀

- Knowledgeable about HIV transmission, HTS, prevention and treatment.
- Anxiety about health care providers' attitude towards young women testing for HIV
- Preference for HIVST

HIVST Experience & Linkage to care

♂

- HIVST is private, confidential
- Men are generally open to self-report, feeling it helps them to access other services
- Prefer health facilities to access care, confidence in quality

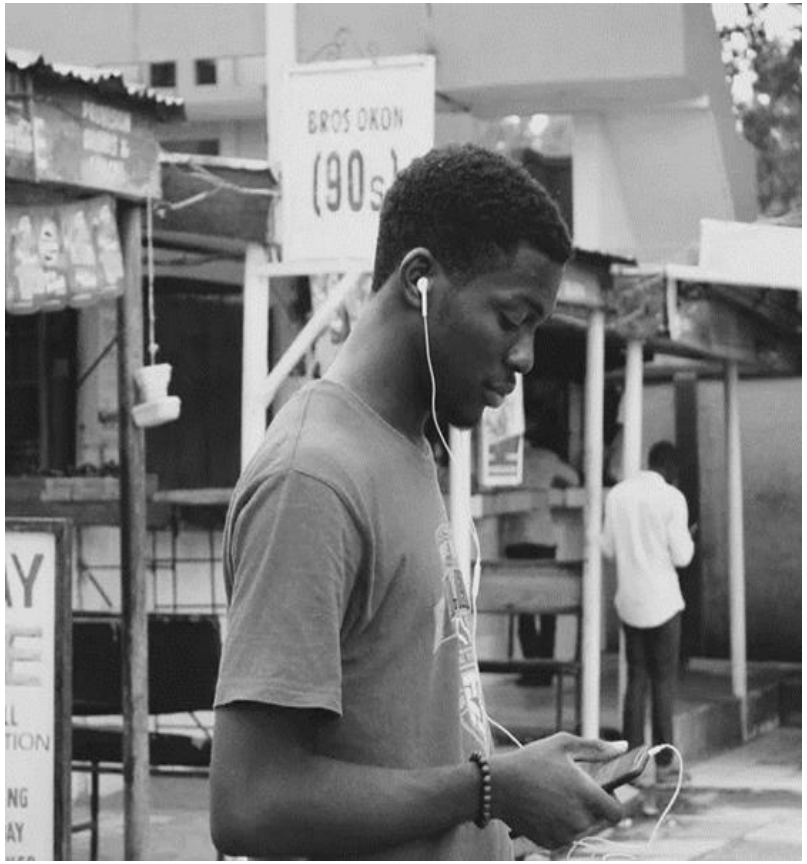
♀

- HIVST is easy, confidential, private
- Preference for blood based products
- Reluctant to self-report, concerns around confidentiality
- Like digital platform, anonymous and confidential

STAR Chatbot Tool

♂

- Useful, rich in information
- Info on PrEP, speed, clarity
- More videos, pictures, less text
- Zero rating to reduce costs, USSD version, additional languages



♀

- SOS information, call-in line, high amount of content
- Ease of use, useful, detailed info
- Call button to talk to human, shorter content
- Zero rating to reduce costs, USSD version, additional languages

Takeaways

- Chatbot provides good opportunity to educate about HIV Prevention, care and testing, promote self-testing, learn how to use self-test kits.
- Chatbot addresses barriers along the client journey, increased uptake and use
- Efficient way to engage with large audience and to access info on health issues and services and access points, especially for young people.
- Multiple languages to accommodate various nationalities and ethnicities.
- Multiple self-test kits and link to other self-care products, FP, PrEP
- Opportunity with human interface and helpline

Next steps Chatbot, new use cases for self-testing

- Chatbot expanding to use with other self-care and self-test options, COVID19 and Hepatitis self testing
- Expansion of HIVST chatbots in Tanzania, Nigeria, Uganda, and Kenya
- New use cases will need to come with strong data to action plans to ensure the interaction meets the requirements of the implementation and is in line with national guidance.

MINISTÈRE DE LA SANTÉ ET DE L'ACTION SOCIALE

Stratégie d'Autodépistage du VIH au Sénégal

Enjeux et défis du suivi-évaluation

Dr Fatou Fall

DIVISION LUTTE CONTRE LE SIDA ET LES IST

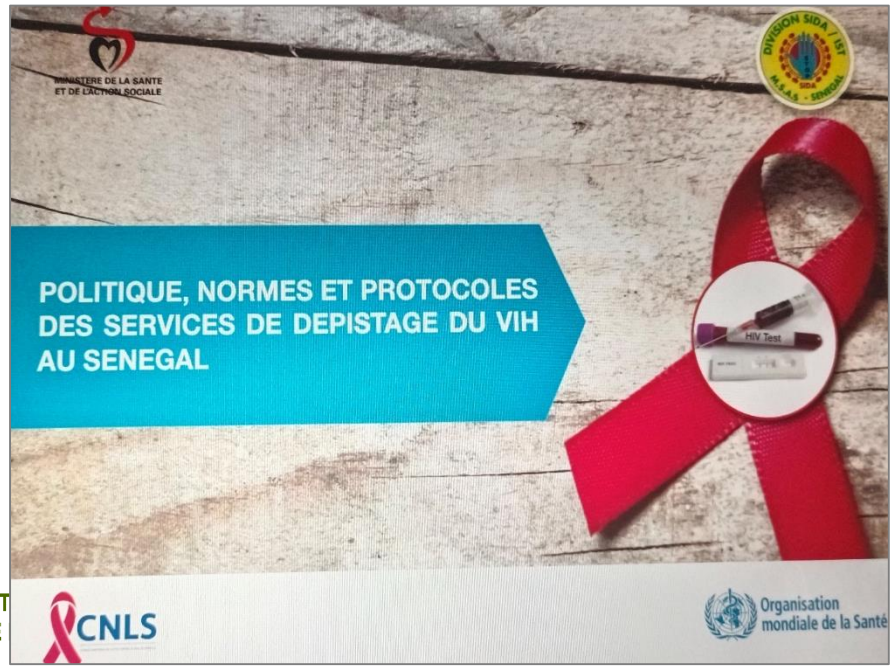
Plan

- ***Généralités***
  - Introduction
  - Justifications
  - Intégration ADVIH dans la politique de dépistage
  - Mise en œuvre au Sénégal
- ***Suivi –Evaluation de la stratégie au Sénégal***
  - Directives et défis de SE
  - SE dans le cadre du projet ATLAS
  - Intégration ADVIH dans le système national de suivi évaluation
- ***Conclusion : enjeux***

Introduction

Le Sénégal a adopté l'autodépistage du VIH dès 2017 suite aux recommandations de l'OMS 2016

Introduction dans le Plan Stratégique National 2018 – 2022



Le Sénégal recommande d'utiliser ADVIH en supplément aux algorithmes nationaux de dépistage du VIH, afin d'atteindre **des populations difficiles d'accès ne fréquentant pas les services de santé** à cause d'une forte stigmatisation et d'une discrimination (***Guide CDV 2018)***

Justification

En 2017 :

➢71 % des PvVIH connaissent leur statut

➢ Les gaps de dépistage sont plus importants chez les hommes, parmi les jeunes, les enfants et les populations clés

➢ Seuls 34 % des HSH et 53 % des PS infectés par le VIH connaissent leur statut.

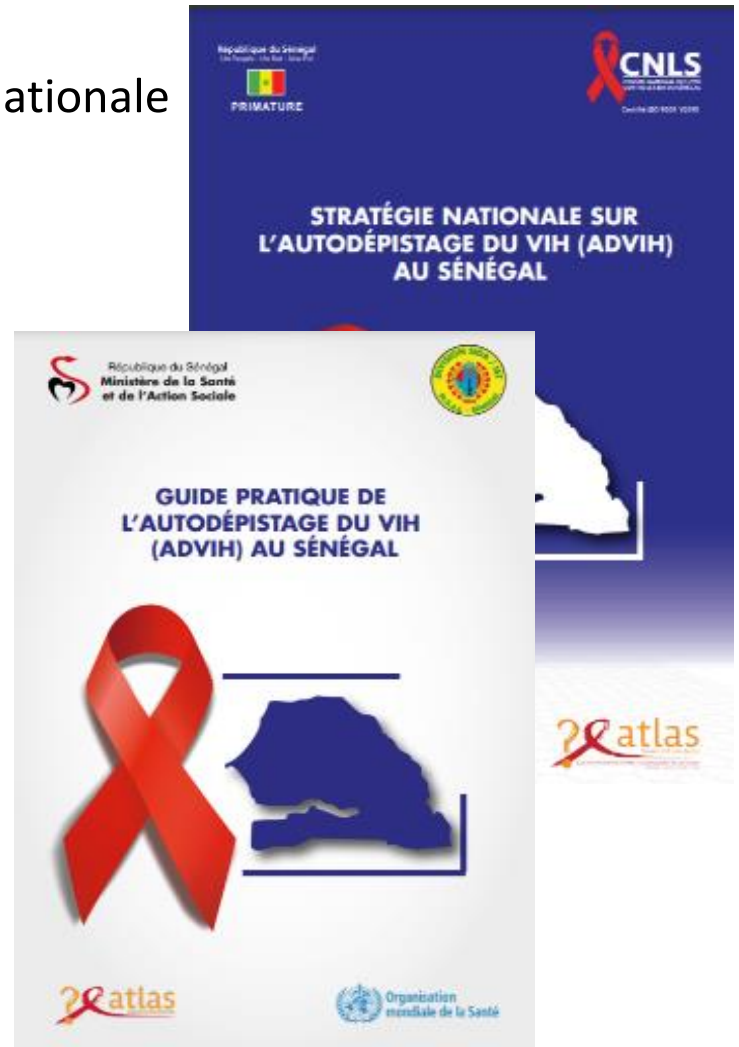
Dans ce contexte, il était nécessaire de diversifier l'offre de dépistage à travers des stratégies innovantes et à haut impact: **ADVIH**

L'ADVIH constitue une forte opportunité d'atteindre des personnes non touchées par des modes « classiques » de dépistage : PS, HSH, CDI, les clients de PS, les partenaires féminines d'HSH, les partenaires de PvVIH, les patients infectés par une IST ou leurs partenaires.

Intégration dans la politique nationale de dépistage

Volonté de développer en 2019 une stratégie nationale spécifique à l'autotest du VIH

- Élaboration de guidelines : ***Stratégie Nationale de l'Autodépistage au Sénégal*** et ***Guide Pratique de l'Autodépistage du VIH au Sénégal***
- Cibles prioritaires du programme populations clés « cachées » et autres populations difficiles d'accès
- Dispensation en communauté privilégiée suivant les recommandations OMS
- Volonté d'aboutir à un accès libre en pharmacie



Mise en œuvre au Sénégal

Projet pilote de ENDA Santé/John Hopkins University

En juillet 2019, le projet ATLAS (Solthis, IRD), financé par l'Unitaid, a initié la dispensation d'autotests dans 3 régions avec un objectif de 63.200 autotests à distribuer sur trois ans.

En 2019, le Fonds mondial, dans le cadre des fonds catalytiques, a financé la distribution des autotests dans les 11 autres régions sanitaires du Sénégal (objectif d'environ 44.000 autotests distribués sur deux ans) auprès des populations clés et leurs partenaires.

En 2021 en contexte de COVID la DLSI a initié la dispensation dans 7 régions au niveau de 13 sites de prise en charge des populations clés.

Le suivi et l’évaluation de la stratégie au Sénégal

Directives de Suivi et évaluation

Pour pouvoir suivre les résultats des programmes d'ADVIH mis en place, il était nécessaire d'intégrer l'ADVIH le dispositif de suivi - évaluation des services de dépistage du VIH constitué :

- Du recueil et de la collecte des données de routine : outils primaires, DHIS2
- De la supervision
- De l'évaluation

Défis du suivi évaluation

Identifier des indicateurs pertinents

Identifier et élaborer les outils de collecte nécessaires

Former les acteurs à l'utilisation correcte des outils et l'intérêt de la complétude et promptitude dans la transmission

Intégrer l'ADVIH dans le système d'information sanitaire national

Assurer la remontée de données de qualité et dans les délais

Mesurer l'impact de la stratégie sur le 1er 90

Apport du projet ATLAS dans le S&E national

- Formation de 29 points focaux S&E et 10 écoutants de la ligne téléphonique gratuite (Hotline)

- Élaboration d'outils de S&E de l'ADVIH qui seront adaptés dans le programme national :

  - Le carnet de dispensation des kits d'ADVIH.
  - La fiche de dispensation mensuelle des kits d'ADVIH (pour les communautaires ou les structures de santé).
  - Registre de suivi des appels (Hotline)

- Intégration d'indicateurs autotests en fonction de la cible dans le DHIS2

Exemple de formulaire autotest DHIS2 Sénégal

PS Sexe et Age : Autotest VIH

Élément de données	H, 15-24 ans	H, 25-49 ans	H, > 49 ans	F, 15-24 ans	F, 25-49 ans	F, > 49 ans
Nombre d'autotests distribués (PS)	20,0	16.0	33,0	52,0	231.0	23,0
Nombre de personnes ayant effectué un test de confirmation au VIH après avoir fait un autotest réactif ou qui ne donne pas de résultats (PS)				3.0	5.0	
Nombre de PS ayant accepté l'autotest	12.0	8.0	1.0	46,0	218,0	12.0
Nombre de PS vues en consultation	16.0	30,0	9.0	479,0	3934.0	415,0

NB : Il existe 5 formulaires dans le DHIS2 pour chacune des cibles suivantes : PS, HSH, CDI, IST, PVVIH

MINISTÈRE DE LA SANTÉ ET DE L'ACTION SOCIALE

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Dans le cadre du projet ATLAS : S&E

Collecte active de ATLAS :

- Remplissage outils primaires par les responsables des sites publics et communautaires
- Mise en place d'un Système de collecte DHIS2 propre (désagrégation des indicateurs plus fine)
- Enquêtes coupons
- Recherche (IRD)

Toutefois …

- Prestataires renseignent les outils de collecte et reporting du projet sans transmission selon le circuit classique dans le système national
- DHiS2 National non renseigné dans la plupart des sites publics (16/21 en Fin Janvier 2022)
- Pas de connexion non plus avec les données communautaires alors que la dispensation communautaire est privilégiée dans le cadre de l'autodépistage

Recueil et collecte des données de routine

Intégration d'indicateurs de suivi ADVIH dans les outils du CDV du programme lors de la dernière révision (2021) en vue de la mise à l'échelle nationale

➢ Collecte de données des sites sanitaires :

- Registres : de consultation, de laboratoire, index – testing, carnet de dispensation des autotests
- Fiches de stock

➢ Collecte des données communautaires :

- Fiches VAD, causeries, dépistage démédicalisé
- Fiches de collecte de la clinique communautaire

➢ Collecte à partir de la ligne verte téléphonique

Le système de S&E national

Recueil et collecte des données de routine

Intégration dans les outils du CDV du programme lors de la dernière révision (2021)

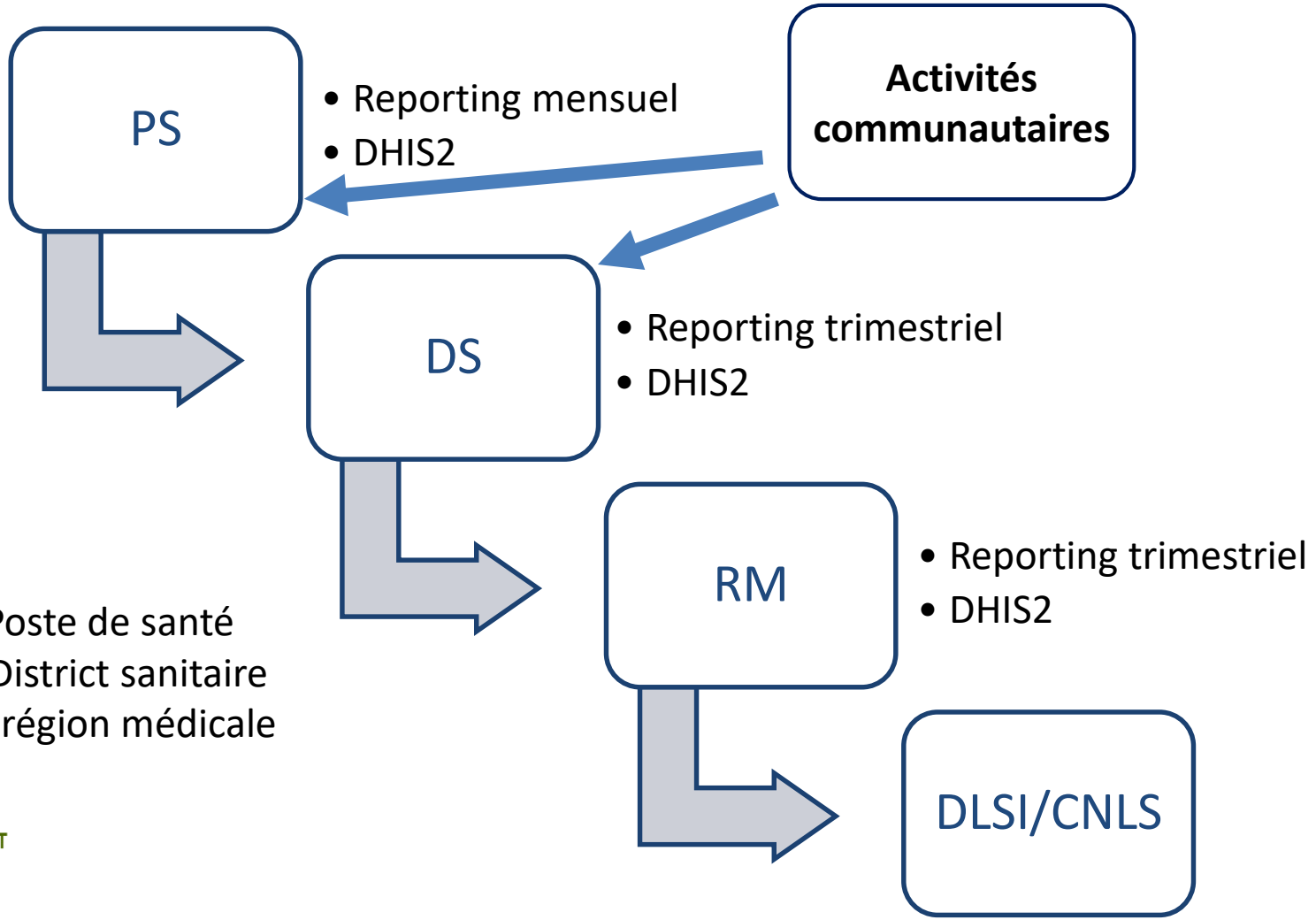
Reporting :

- Rapports : Labo, HSH, PS, Index-testing, IST
- Rapports clinique communautaire (nombre d'autotests distribués et nombre de retours d'autotests enregistrés)
- DHiS2 : 5 formulaires de rapports ADVIH (PvVIH, IST, PS, HSH, CDI) par âge et sexe
- Rapport de gestion de stock

Le système de S&E national

Transmission des données

Données agrégées et transmises selon le circuit de remontée et la périodicité du programme :



PS = Poste de santé
DS = District sanitaire
RM = région médicale

Le système de S&E national

Supervisions

La supervision de l'ADVIH est intégrée à la supervision des services de dépistage du VIH (SDV)

Une supervision semestrielle et / ou en cas de besoin est prévue

Le système de S&E national

Evaluation

Analyse des indicateurs de suivi direct et mesures de l'impact indirect de l'ADVIH

Indicateurs de suivi directs :

Nombre de kits d'AT dispensés (par sexe et âge)

Nombre de personnes reçues pour confirmation au laboratoire suite à un autotest réactif

Nombre de kits d'AT vendus en pharmacie

Mesure de l'impact indirect : enquêtes spéciales, démographiques (EDS) ou surveillance bio-comportementale intégrée (IBBS)

Triangulation de données : données de TAR / résultats d'enquêtes spéciales – mesures d'impact – analyse des progrès et ajustement des prestations

Conclusion

Dans un contexte de démarrage de la mise à l'échelle de l'autodépistage au Sénégal les enjeux pour le programme sont :

Assurer une remontée des données efficace intégrant les autres volets du SDV en l'absence de l'appui technique et financier des partenaires dans le cadre du projet

Assurer la transmission des données communautaires vers les districts sanitaires d'où elles seront capitalisées (polarisent les zones où se déroulent les activités)

Persistance le problème de suivi post dispensation : traçabilité de l'utilisateur final, résultat, retour d'information vers le système (suivi proactif non coercitif ??)

Seules les mesures d'impact indirect permettront d'estimer l'apport de l'autodépistage sur le 1er 95.

MINISTÈRE DE LA SANTÉ ET
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M.S.A.S - SENEGAL

Monitoring and Evaluation of HIV Testing and Self-Testing - Global Fund

Workshop April 4th 2022

Dr. Obinna Onyekwena

HIV Advisor, Technical Advice and Partnerships

Overview

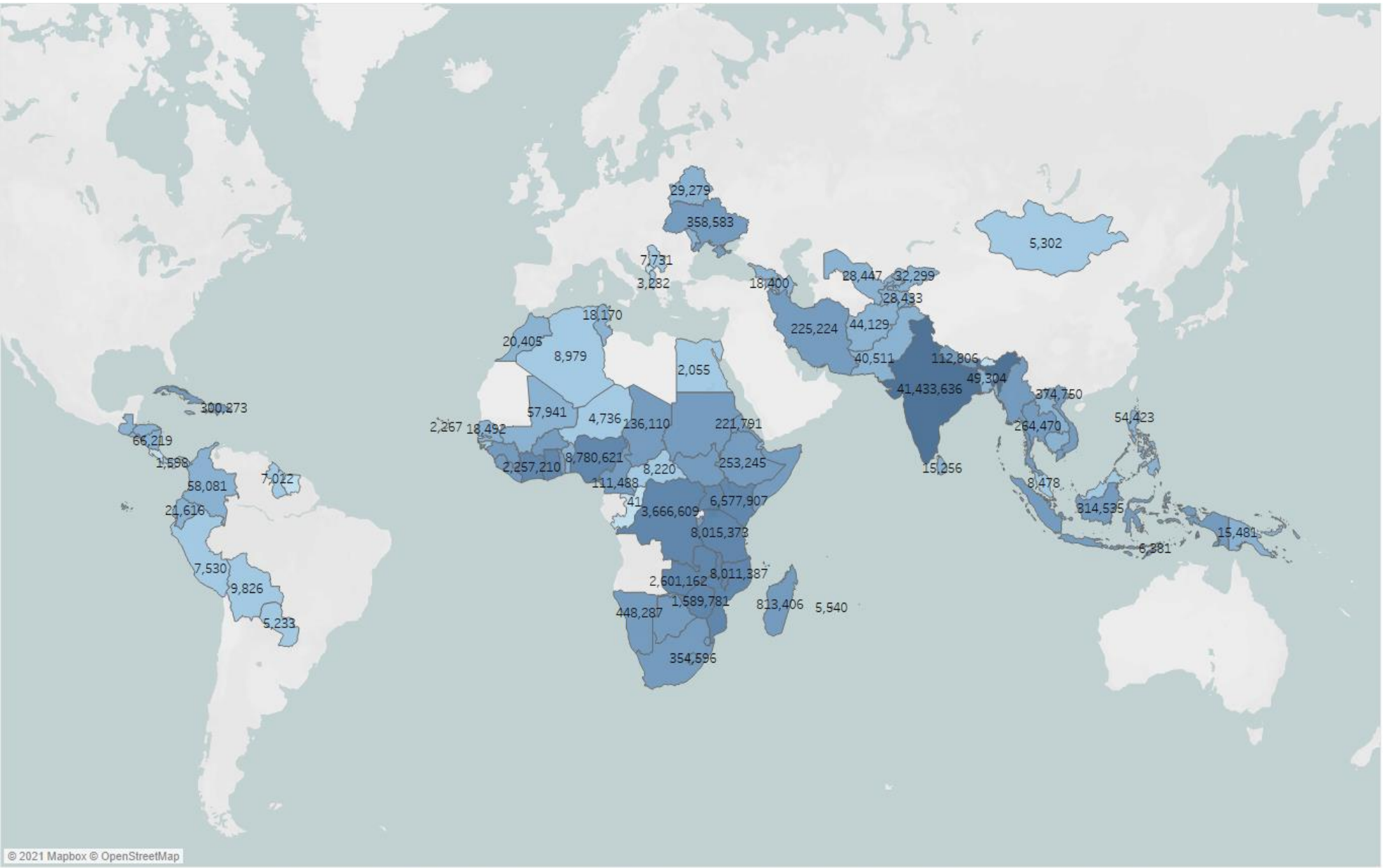
M&E of HIV Testing services at the Global Fund uses a mix of programmatic, budgetary as well as procurement data.

- Programmatic data include HIV Testing Volumes, Overall and stratified by Key Populations
  - Self Testing distribution data will become available from NFM4 (2024)

- NFM3 HIV Testing Budget (Including Self-Testing)

- Procurement Data through PPM 2018-2021: A fast changing landscape

103M HIV tests in 99 countries in 2020

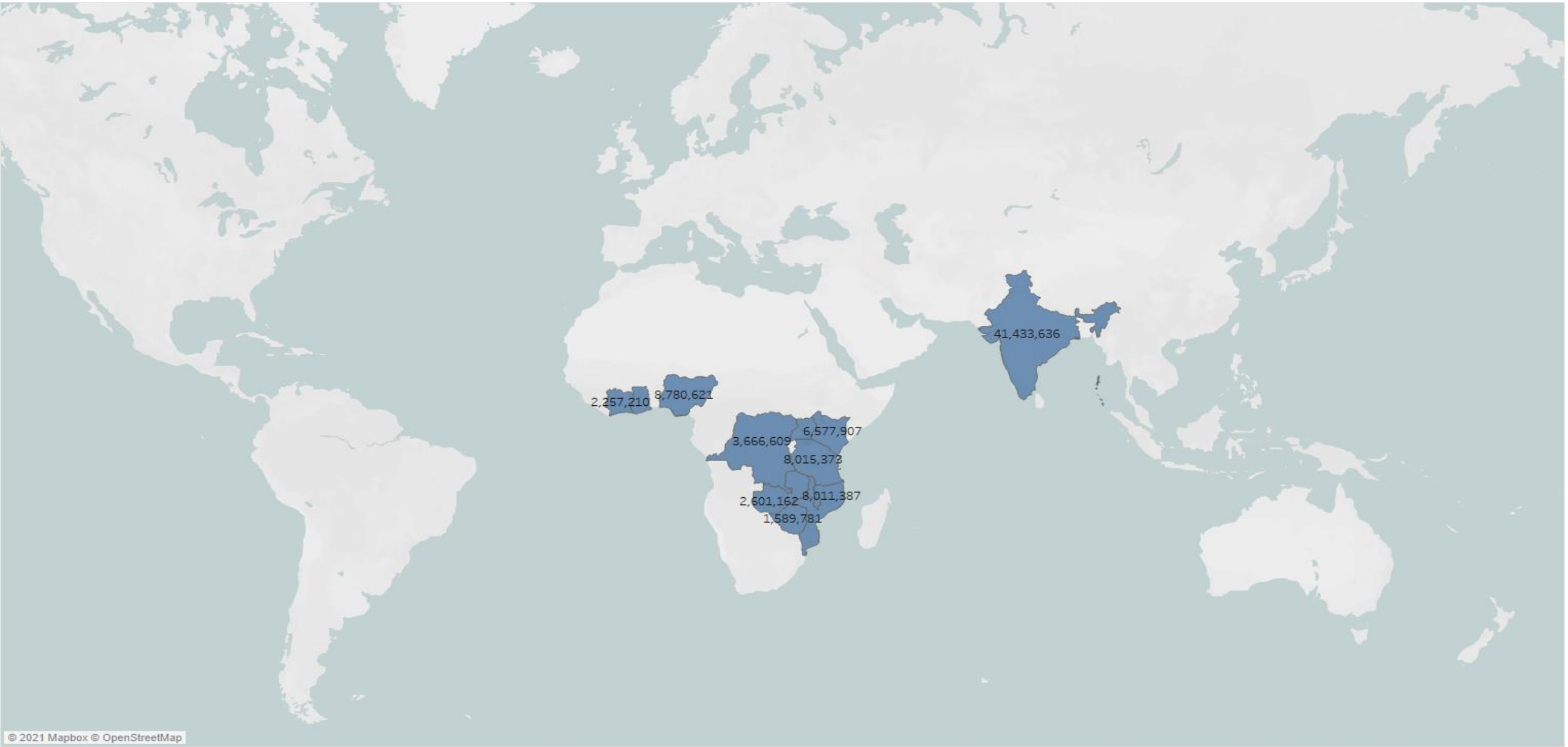


Number of tests done in 2020

- less than 1000
- btw 1,001 & 10,000
- btw 10,001 & 100,000
- btw 100,001 & 1,000,000
- btw 1,000,001 & 10,000,000
- More than 10,000,000

Map based on Longitude (generated) and Latitude (generated). Color shows details about Number of tests done in 2020. The marks are labeled by sum of Tests2020. Details are shown for Country Code.

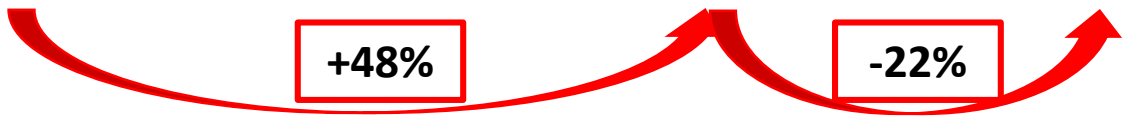
89.4% of HIV Testing volume in just 12 countries



Map based on Longitude (generated) and Latitude (generated). The marks are labeled by sum of Tests2020. Details are shown for Country Code. The data is filtered on Number of tests done in 2020, which keeps btw 1,000,001 & 10,000,000 and More than 10,000,000.

GF reported HIV testing volume, 2017-2020

	2017	2018	2019	2020
General population (%)	84,749,238 (**94.0**)	121,743,761 (**95.8**)	127,338,175 (**95.2**)	98,329,695 (**94.5**)
Key Population	4,521,631 (**5.0**)	4,405,503 (**3.4**)	5,255,442 (**3.9**)	4,518,767 (**4.3**)
Sex workers	1,213,244	1,018,694	1,276,922	1,280,357
Men who have sex with men	1,056,260	1,196,996	1,434,119	1,271,400
People who use drugs	501,496	771,832	774,059	749,754
Prisoners	64,592	453,815	740,702	489,928
Transgender population	74,648	87,857	106,438	77,364
Other vulnerable population	1,611,391	876,309	923,202	649,964
EID	427,074	431,530	435,500	418,342
Adolescents and youth	466,591	490,630	715,680	705,709
Total	**90,164,534**	**127,071,424**	**133,744,797**	**103,972,513**



Key population HIV Testing results, 2017-2020

	2017	2018	2019	2020
Sex workers	1,213,244	1,018,694	1,276,922	1,280,357
Men who have sex with men	1,056,260	1,196,996	1,434,119	1,271,400
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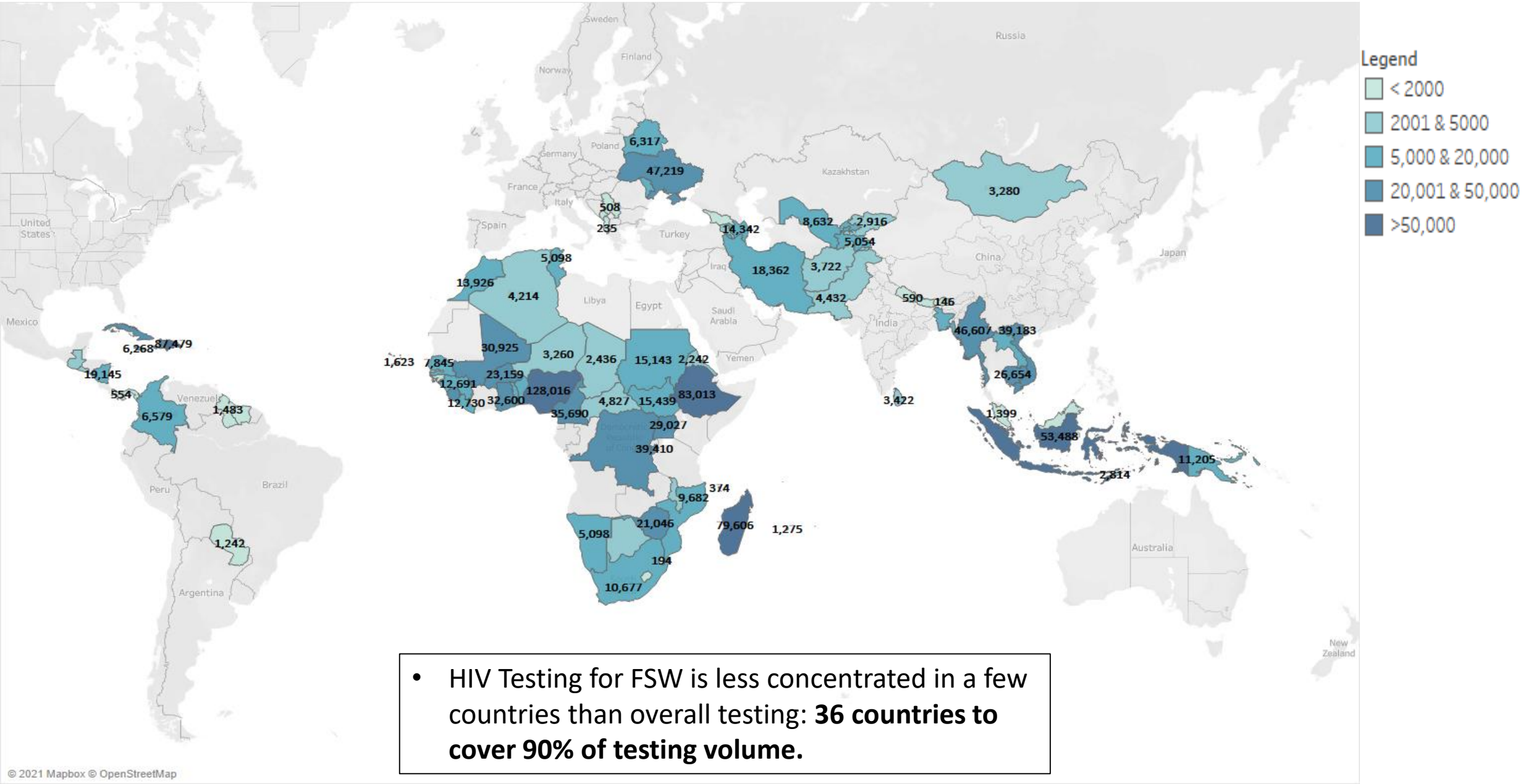
Transgender population	74,648	87,857	106,438	77,364
Other vulnerable population	1,611,391	876,309	923,202	649,964
Total (%)	4,521,631 (**5.0**)	4,405,503 (**3.4**)	5,255,442 (**3.9**)	4,518,767 (**4.3**)

Key Messages:

- **Between 2018 & 2020, KP Testing targets increased by 34% from 5.1 to 6.9M tests.**
- KP HIV Testing volumes increased by **19% in 2019**
- **2020: Falling further behind from targets.**
  - HIV Testing volumes reduced by 14%
  - Performance 2020 was 65% vs 87% in 2019

HIV Testing among SW in 2020: 1.3M in 82 countries



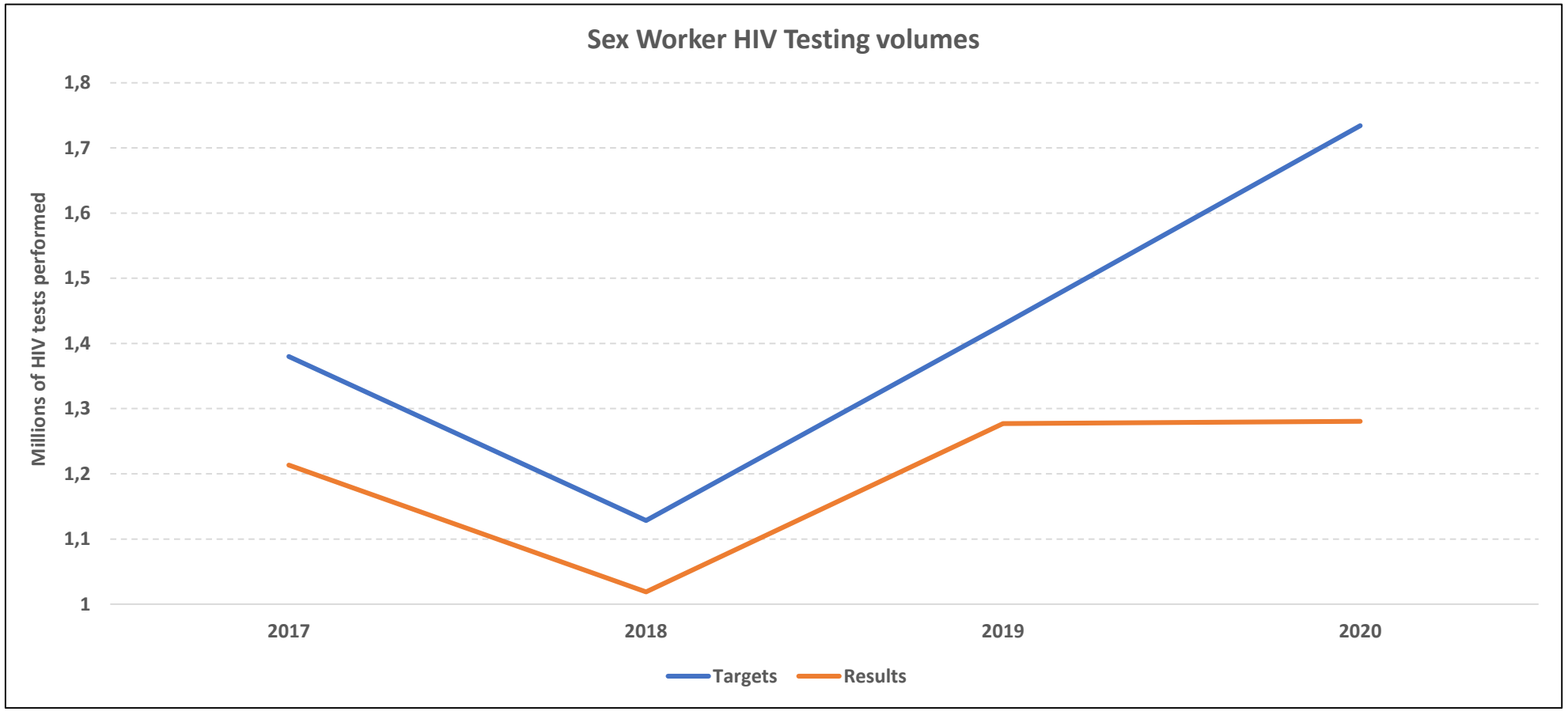
- HIV Testing for FSW is less concentrated in a few countries than overall testing: **36 countries to cover 90% of testing volume.**

Map based on Longitude (generated) and Latitude (generated). Color shows details about Legend. The marks are labeled by sum of Sum of ResultNumerator 2020. Details are shown for Row Labels.

Geographical distribution of HIV Testing among FSW

	2018 n(%)	2019 n(%)	2020 n(%)
Sub-Saharan Africa	452,016 (44.4)	627,347 (49.1)	671,596 (52.5)
America	266,792(26.2)	294,265 (23.0)	242,933 (19.0)
Asia	169,324(16.6)	205,578(16.1)	214,645 (16.8)
MENA	55,122 (5.4)	63,176(4.9)	56,062 (4.4)
EECA	75,440 (7.4)	86,556 (6.8)	95,121 (7.4)
Total	1,018,694	1,276,922	1,280,357

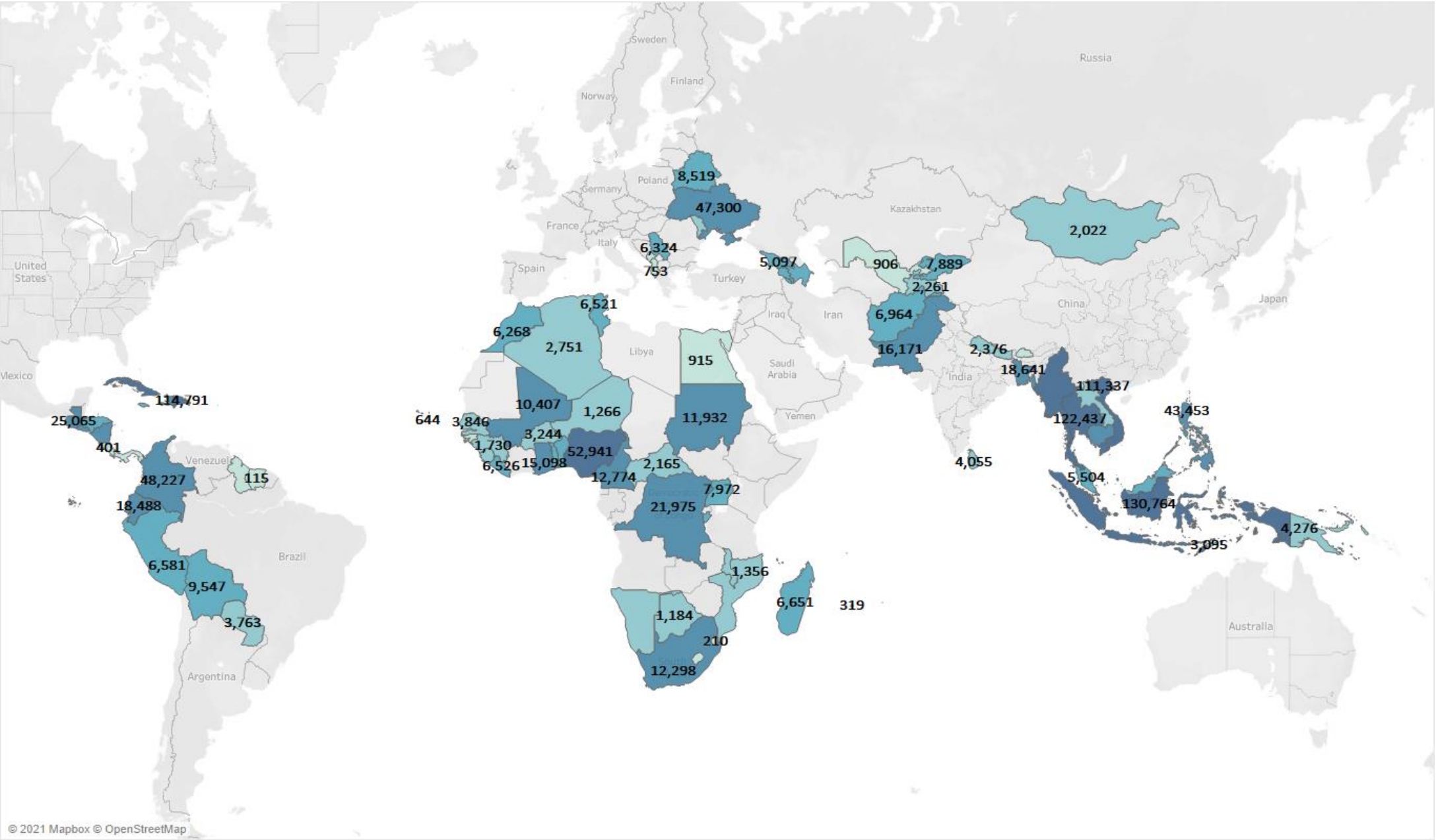
2020 HIV Testing among SW: Targets vs Results



Key messages:

- Testing targets for SW increased by 21% between 2019 & 2020
- The number of tests performed remained stable ~ 1.3M
- Overall performance against targets decreased from **89 to 74%**
- Strong heterogeneity between countries: **43 countries increased testing and 27 improved performance.**

HIV Testing among MSM in 2020: 1.3M in 91 countries



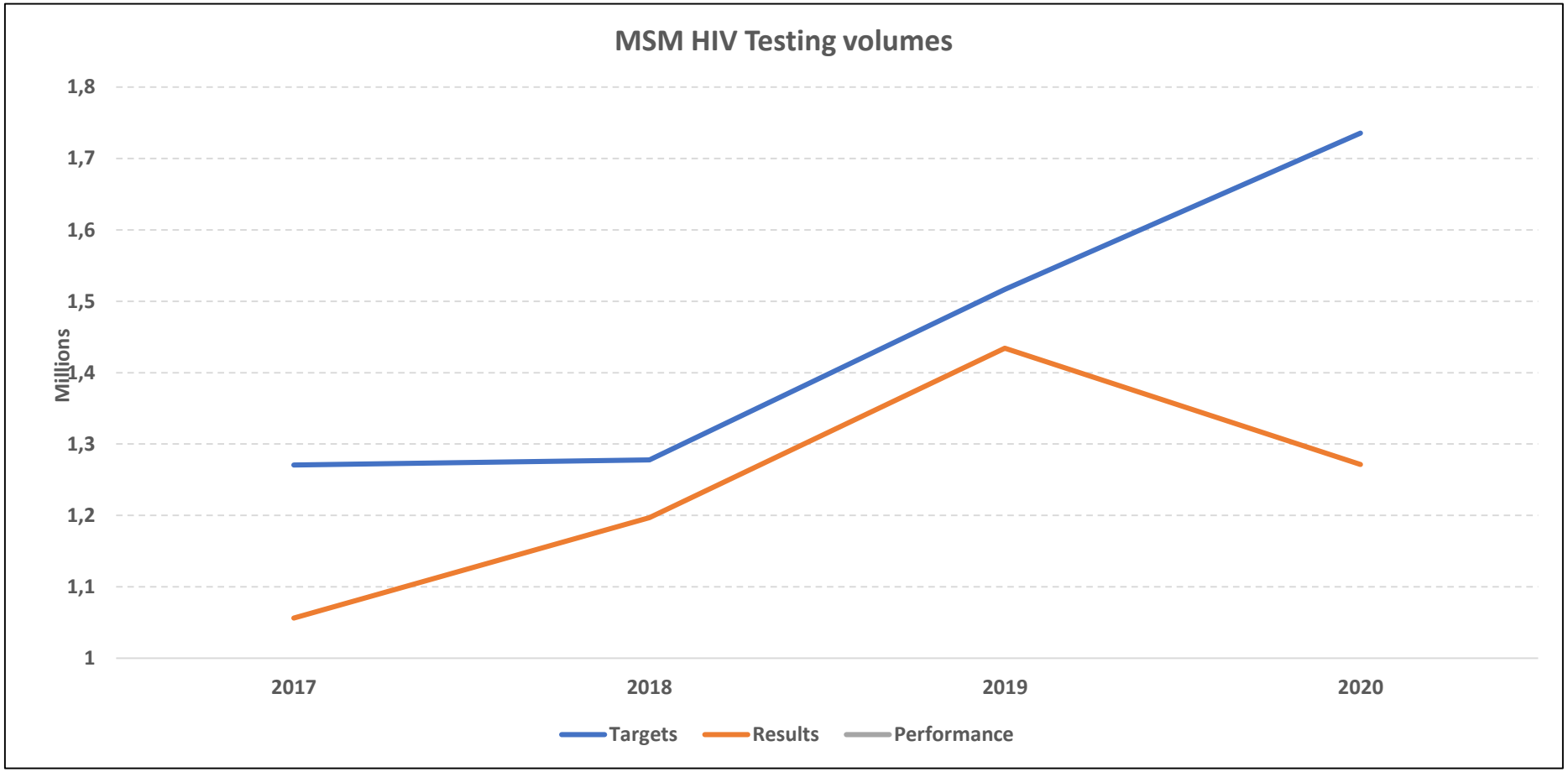
Map based on Longitude (generated) and Latitude (generated). Color shows details about F5. The marks are labeled by sum of Sum of ResultNumerator 2020. Details are shown for Row Labels.

Geographical distribution of HIV Testing among MSM

	2018 n(%)	2019 n(%)	2020 n(%)
Sub-Saharan Africa	114,259 (9.5)	149,827 (10.4)	195,827 (15.4)
America	527,439 (44.1)	577,982 (40.3)	393,847 (31.0)
Asia	452,721 (37.8)	575,185 (40.1)	553,600 (43.5)
EECA	71,468 (7.8)	97,447 (6.8)	99,739 (7.8)
MENA	31,109 (2.2)	33,678 (2.3)	28,387 (2.2)
Total	**1,271,400**	**1,434,119**	**1,196,996**

- MSM
- HIV testing among MSM in SSA increased by 71% between 2018 & 2020. Targets for 2020 in SSA was 201,681 and performance 97%

2020 HIV Testing among MSM: Targets vs Results



Key messages:

- Testing targets for MSM increased by 14% between 2019 & 2020 (from 1.5 to 1.7M test)
- The number of tests done decreased by 11% from 1.43 to 1.27M
- Overall performance against targets decreased from **94 to 73%**
- Strong heterogeneity: 44/83 increased HIV testing while 23/83 improved performance.

LAC countries were the most impacted in 2020

- HIV Testing among MSM decreased from 577,982 in 2019 to 393,847 in 2020 **(-32%)**
- Testing Target increased from 637,709 in 2021 to 729,089 in 2020
- Performance decreased from 90.6 to 72.3%
- The decrease is not homogenous:
  - Mostly driven by Peru (-105k) and Cuba (-60k)
  - 5/14 countries increased their testing volumes in 2020

Procurement: HIV Tests & Self Tests ordered using PPM* (2020-21)

Number of HIV tests ordered in 2020 & 2021

	2020	2021
Duo Test	3,749,850	7,881,450
Self-Tests	1,969,094	5,249,702
Other HIV RDT	78,814,905	57,198,427
Total	**84,533,849**	**70,329,579**

Market share of the 4 most ordered HIV Tests in 2020

	2020	2021
Test A	57.6%	43.3%
Test B	21.9%	25.2%
Test C (Duotest)	3.3%	11.0%
Test D (ST)	2.2%	6.2%

- HIV/Syph Duotest and HIV ST represented **18.7%** of all HIV rapid tests in 2021, up from **6.8% in 2020**
- The main Duotest and ST kits ordered are now overall 3rd and 4th HIV tests ordered in 2020
- The market share of the main test ordered reduced for the first time <50% of all tests ordered. However, the company still represented 80% of the market and 3 out of 4 of the top tests ordered.

* This only ST kits purchased through the wambo system. Kits purchased outside of the PPM by countries do not appear here

HIV Self-Tests kits ordered using PPM* (2018-21)

Number of HIV Self-Tests kits ordered using PPM (2019-2021)

	2019	2020	2021
ST Kits	1,954,650	1,969,094	5,249,702

Number of countries who ordered HIV Self-Tests kits using PPM (2019-2021)

	2019	2020	2021
Countries	3	18	30

In 2021, one supplier represented **84.2%** of the total market.

Countries where ST were ordered in 2021: Malawi, Uganda, Mozambique, Nigeria, Cameroon, Lesotho, Ghana, Swaziland, Mali, Philippines, Namibia, Belarus, Burkina Faso, Liberia, Thailand, Senegal, Cote d'Ivoire, Zambia, Armenia, Benin, Guatemala, Sri Lanka, DRC, Nepal, Eritrea, Togo, Madagascar, Gambia, Niger

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HIV Self-Tests kits ordered using PPM* (2018-21)

Number of HIV Self-Tests kits ordered using PPM (2019-2021)

	2019	2020	2021
Cameroon, Uganda, Mozambique, Nigeria	4,600	7,300	2,652,966
Other Countries	1,950,050	1,961,794	2,596,736
Total	1,954,650	1,969,094	5,249,702

- Most of the increase in ST ordered in 2021 because of ST scale-up in ST Matching Fund countries.
- ST Matching Fund countries: 4 out 5 biggest ST orders in 2021

* This only ST kits purchased through the wambo system. Kits purchased outside of the PPM by countries do not appear here

HIV Self-Tests kits ordered in Malawi, Lesotho, Eswatini* (2018-21)

Number of HIV Self-Tests kits ordered using PPM in Malawi, Eswatini and Lesotho (2019-2021)

	2019	2020	2021
Malawi	1,152,000	950,000	1,200,000
Lesotho	267,000	223,018	256,400
Eswatini*	0	0	183,800

* 2020 ST kits were provided by PEPFAR in Eswatini

In those 3 countries:

- Most of ST kits delivery happen in facilities and not in KP projects
- COVID-19 accelerated ST scale-up but introduction started prior to COVID or was planned regardless of COVID-19

* This only ST kits purchased through the wambo system. Kits purchased outside of the PPM by countries do not appear here

Discussion (I): Self-Testing within GF supported programs

- In 2021, ST represented **7.4%** of the total number of HIV serologic RDTs procured. A rapid evolution of the type of tests ordered.
  -> CIFF Countries, represents the vast majority of the 2021 increase in ST orders.

- The examples of Malawi, Lesotho and Eswatini suggest that full scale-up of ST will only happen through government facility distribution mechanism. HIV testing in KP programs although increasing, represents only 5% of all HIV tests reported in 2020, which were severely impacted by COVID-19.

- **Covid-19 as an accelerator for transition to Self-testing and Self-Care: ST is one the 5 “must-have adaptation**

- WHO (and PEPFAR in its last COP guidance) has recently advised against the use of HIV screening tools (screen-out) which partly explain the reduction of HIV tests
  -> Use of ST as a screening tools.

Discussion (II): Self-Testing within GF supported programs

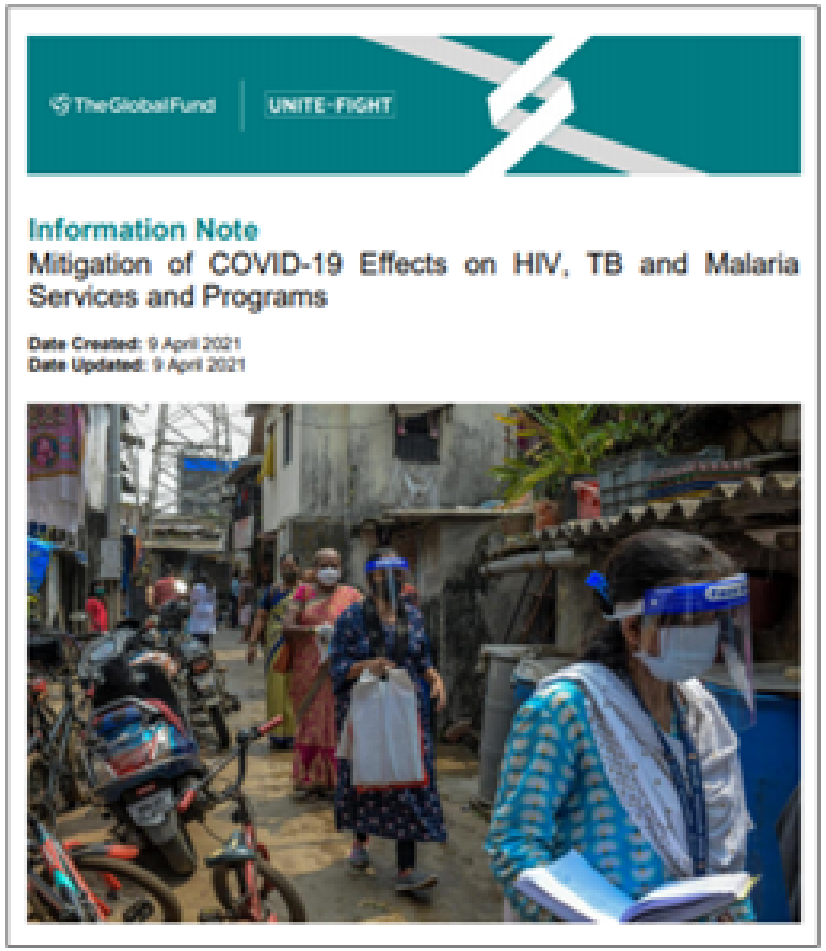
- An evolving market land scape:
  - New actors, including Abbott, are coming into the market with a reduced price (1.4 USD announced)
  - Soon a HIV ST kits at 1 USD??
  - Will it change the cost effectiveness of current VCT programs ?

- HIV Self Testing for PREP Initiation and Monitoring

- Potential future use of HIV Self-Tests:
  - Hard to reach populations (KP, Index testing)
  - Screening Tool in high burden countries
  - PREP
  - Self-Care, other means of distribution (online, pharmacies, retail stores, vending machines). Total Market approach, in association with other self Tests (Syph) or products (Emergency contraception, PEP, PREP…).

- All M&E should consider potential new usage and ways of distribution of HIV ST.

C-19RM 2.0– HIV Mitigation Activities "5 Must haves"



1. **Multi-month dispensing** of prevention, care and treatment products (*ART, PrEP, Condoms/lube, injecting supplies/naloxone/OST*)
2. **Out-of-facility dispensing** of prevention, care and treatment products *(pharmacy, community, outreach, virtual)*
3. **Virtual service delivery** through telephone or online platforms *(triage, linkage, follow-up, adherence and other support)*
4. **Differentiated HIV testing** – including self-testing (HIVST) and out-of-facility models
5. **KP and AGYW Prevention Programming adaptations** *(PPE, smaller group sizes, mobile/outreach/virtual enhancement)*

DISCUSSION

Chaired by Nayé BAH, WHO

Panelists :

- Anne BEKELYNCK, WHO
- Anthony Vautier, Solthis/ATLAS
- Arlette Simo FOTSO, IRD/Ceped/ATLAS
- Karin HATZHOLD, PSI/STAR
- Fatou FALL, DLSI, Sénégal
- Obinna ONYEKWENA, Global Fund