Targeted adolescent HIV testing in two South African health sub-districts

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BACKGROUND

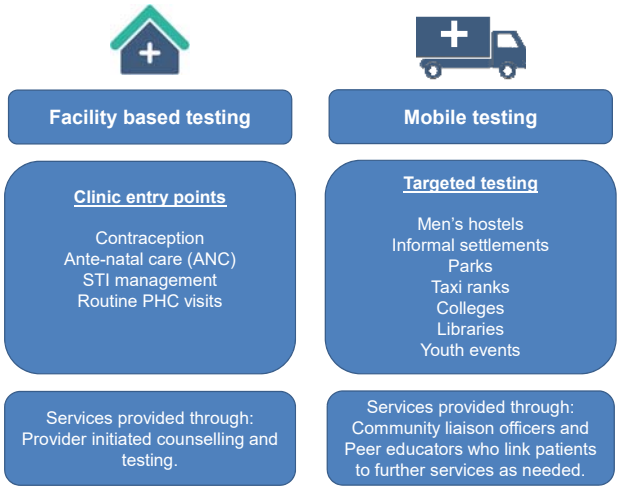
Rates of HIV testing have increased generally in South Africa. However, HIV testing rates for first time and repeat tests among adolescents and young people remain generally low, and young men have particularly low rates of accessing HIV services and care[1]. This is an important gap because HIV testing is an essential entry point to HIV care and treatment, and also for accessing effective biomedical prevention services such as medical male circumcision or pre-exposure prophylaxis (PrEP).

Wits RHI's USAID-funded Adolescent Innovations Project (AIP) has developed, implemented and evaluated a replicable model of targeted and linked interventions to improve the screening, testing, diagnosis, quality of care, adherence, retention and transition of adolescents aged 10-25 years living with HIV.

The AIP is implemented in collaboration with the Department of Health in 31 public health facilities in two health sub-districts: Sub-District F, City of Johannesburg and Matlosana, North West Province, South Africa.

DELIVERY MODEL

During 2017, the AIP systematically leveraged all appropriate clinic entry points and expanded out-of-facility testing through mobile and community testing services in order to increase HIV testing and improve service access in hard to reach populations.



METHODS

Data from HIV testing services activities was routinely collected by service providers in all testing modalities. Data was manually captured in registers, and included: patient age, gender, test result, and whether the test was a first-test or a repeat. Young people who tested positive were linked to care through referrals to facilities that initiate ART and were assisted by linkage officers (Health Connectors) who followed up to make sure that patients were properly supported.

Twelve-month HIV testing services data (January-December 2017) were analysed, from a time period of intensive, targeted HIV testing promotion and of data collection improvement activity.

References
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RESULTS

PERFORMANCE During the twelve month period in 2017, 37 532 HIV tests were recorded in the age group 10-25 years. Of all HIV tests performed, 81% (30 324/37 532) were conducted in primary health care facilities and 19% (7208/37 532) were carried out in mobile clinics or community settings.

HIV POSITIVITY The overall HIV positivity rate across the two sub-districts was 7.3% (2732/37 532). Positivity was higher in primary health facilities (7.8%) than in mobile clinics and community settings (4.9%).

GENDER Females received 80% of all tests and 80% of all positive results in facilities; 60% of all tests and 79% of all positive results in mobile/community settings. Proportionally, twice as many males tested in mobile/communities settings than facilities (40% vs 20%), with higher positivity rates (21% mobile/community vs 20% facilities).

AGE More tests were performed in 20-24 year olds (58% of facility tests vs 70% of mobile/community), who also had the highest proportion of positive results (66% of facility positives vs 73% of mobile/community positives). Patients aged 15-19 years comprised one quarter of tests performed (23% in facility vs 26% in mobile/community) and 14% of positive results in facility and 20% in mobile/community.

REPEAT TESTING Repeat tests accounted for 67% of all tests done in facilities, and 28% in mobile/community.

	Facility based testing		Mobile testing	
	Total tested N = 30324	Tested positive n = 2376	Total tested N = 7208	Tested positive n = 356
Region	n (%)	n (%)	n (%)	n (%)
Region F	13101 (43)	1470 (62)	3892 (54)	128 (36)
Matlosana	17223 (57)	906 (38)	3316 (46)	228 (64)
Gender				
Female	24186 (80)	1913 (81)	4329 (60)	280 (79)
Male	6138 (20)	463 (20)	2879 (40)	76 (21)
Age Category				
10-14	1332 (4)	37 (2)	196 (3)	6 (2)
15-19	7052 (23)	324 (14)	1850 (25)	71 (20)
20-24	17668 (58)	1564 (66)	5041 (70)	259 (73)
25	4272 (14)	451 (19)	121 (2)	20 (5)
Repeat tests				
Total	20245 (67)		1991 (28)	

CONCLUSION

Most HIV testing is performed in health care facilities where higher positivity rates are found as compared to mobile/community settings. Leveraging primary health care service entry points is an important strategy for integrated HIV counselling and testing services, with linkage to prevention or ART services for young people. However, mobile testing is an important entry point for harder to reach populations, including males and first time testers.

These two testing modalities are complementary to each other and both are needed to provide adequate HIV testing service coverage. As a stand alone intervention, each modality plays an important role in increasing access to HIV testing and linking patients who are HIV positive to care.

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