CONTROLLING THE HIV EPIDEMIC WITH ANTIRETROVIRALS

Having the Courage of Our Convictions

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STRATEGIC LESSONS FROM THE FRONTLINES

From home-based testing to ART

Implementation lessons: ANRS 12249 TasP in South Africa

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Main hypothesis (formulated in 2010)

Universal Test and Treat

i.e. HIV testing of all adult members of a community, followed by immediate ART initiation of all of those identified as HIV-infected

(regardless of immunological or clinical staging)

will prevent onward transmission
and **reduce HIV incidence** in this population

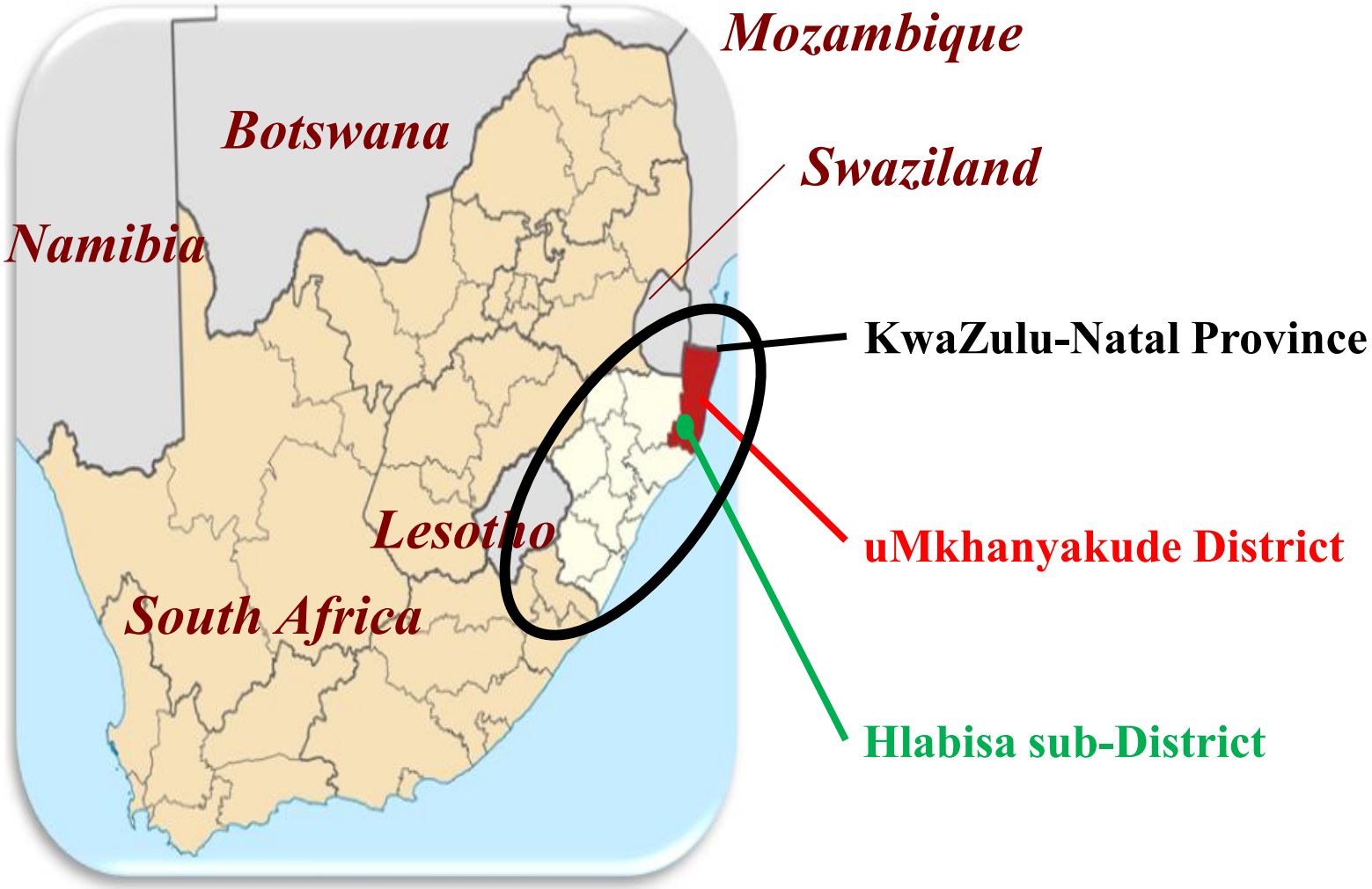
ANRS 12 249 TasP trial design

- **Cluster randomized trial**
  - Cluster = a population of approx. 1,250 adults (16+ years)

- In all clusters, rounds of **home-based HIV testing** repeated every ~ 6 months
- All HIV+ identified participants are referred to local TasP clinics (at least one clinic per cluster)

Control clusters	Intervention clusters
ARV treatment according to South African guidelines (<350 CD4 or WHO stage 3 or 4) **(since Jan. 2015, <500 CD4)**	ARV treatment regardless of CD4 or clinical staging

Where the trial takes place
Hlabisa



Hlabisa - Understanding the context

- **Rural area with scattered housing**

- **One of the poorest areas in South Africa**
  → 2011 *national census*: 43 % unemployment

- **Migration** ++ to cities (studying, work, …)

Hlabisa sub-District

Descriptive epidemiology of HIV infection

- **Prevalence in 2011: >29 %** among the 15-49 years old
- **Important disparities by age and gender**

	♀	♂
15-19 yrs	14.7 %	7.0 %
20-24 yrs	26.5 %	10.2 %
25-29 yrs	38.3 %	16.0 %
30-34 yrs	47.1 %	27.3 %
35-39 yrs	50.4 %	32.0 %
40-44 yrs	49.1 %	35.8 %
45-49 yrs	50.3 %	39.1 %

(Zaidi et al, 2013)

HOME-BASED HIV TESTING

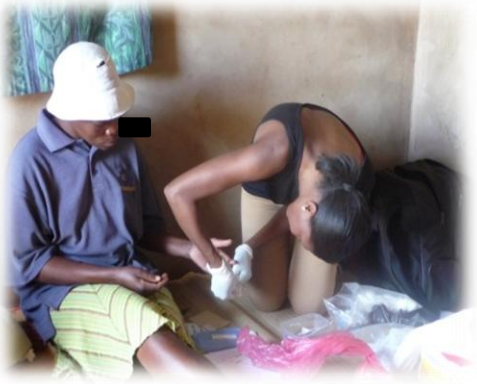
What is it? Why? How?

Some lessons learnt in the ANRS 12249 TasP trial: feasibility, acceptability and subsequent linkage to care

Home-based HIV testing
Principles

- To offer rapid HIV testing at home to all adult members residing in a community by dedicated counsellors

Home visit by a counsellor and proposal of rapid HIV test → **When agreed, choose a place to respect privacy** → **Test procedure**
-Pre-test counselling
-Rapid HV test
-Post-test counselling → **HIV+ referred to clinic**

Home-based HIV testing
Is it appropriate for implementing and evaluating a TasP intervention?

- **Recommended by WHO to increase the HIV testing coverage, especially when**:
  - **Prevalence of HIV is high**
  - **Access to HIV counselling and testing services is sub-optimal**
    - Hlabisa:
      - Rural area → difficulties to access all health services
      - HIV test often but not systematically proposed in primary health care services
- Home-based testing already introduced and evaluated in 2009-2011 by local authorities. Good acceptance by the population.
  - ***Maheswaran et al, JAIDS 2012***

Home-based testing
Specificities in the context of the TasP trial

- **Repeat offer of HIV testing**
  - At home
  - Every six months
  - To all adults **≥16 years** residing in the study area
  - By counsellors trained for and by the trial

- **In parallel, biomedical and social science data collection at each survey round for research purposes by trial staff:**
  - Blinded DBS (Dry Blood Spot) to estimate HIV incidence in the population
  - Socio-demographic and economic questionnaires

Home-based HIV testing

What have we learnt within the TasP trial

based on data collected in 2012-2014?

1. This home-based approach is quite acceptable

Poster
Larmarange et al
(R4P 2014)

2. Referring those identified HIV+ to clinics is not a straightforward exercise

Oral presentation
Plazy et al
(IAS 2015)

Home-based HIV testing is acceptable in TasP

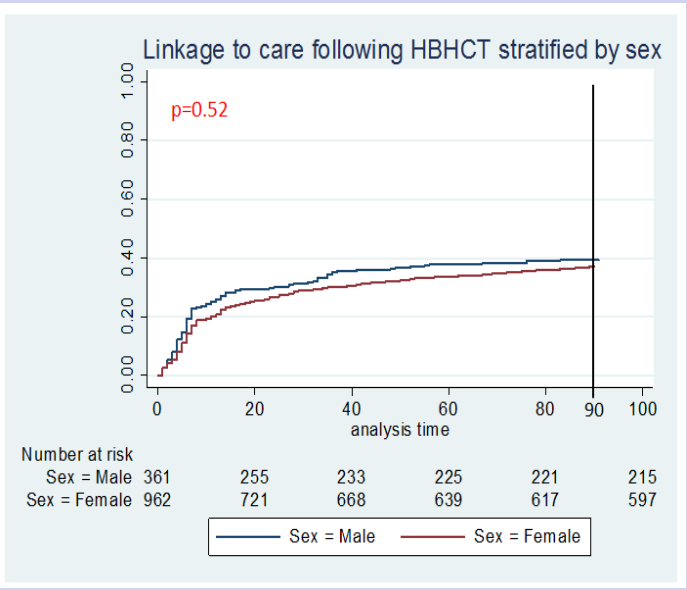
- Eligible population: 12 894
- **25 % could not be contacted**
  - Limited demographic data and reasons remain largely unknown
- **Good acceptance** of home-based HIV testing by **those ever contacted:**
  - At first contact: **≈ 77 %**
  - At second contact:
    Among those HIV-neg at first contact: **>85 %** → repeat testing
    Among those who had refused the first contact/test: **>47 %**

Acceptance more limited by
-Men
-20-30 years

- **Good opportunity to re-identify those already known as HIV-pos to offer them a second chance to refer them to clinic**
  - **≈ 30 % of the HIV-pos had already been diagnosed and half of them had used at least once the local HIV program**

Home-based HIV testing provides partial opportunities to link PLWHIV into care

- Eligible population: 1 323 individus identified HIV+, had never been in care before, and now referred to clinic
  - Followed up ≥3 months and not deceased
- **<38 % will use a clinic at least once** (TasP clinic or DoH local clinic within 3 months after having being invited for referral



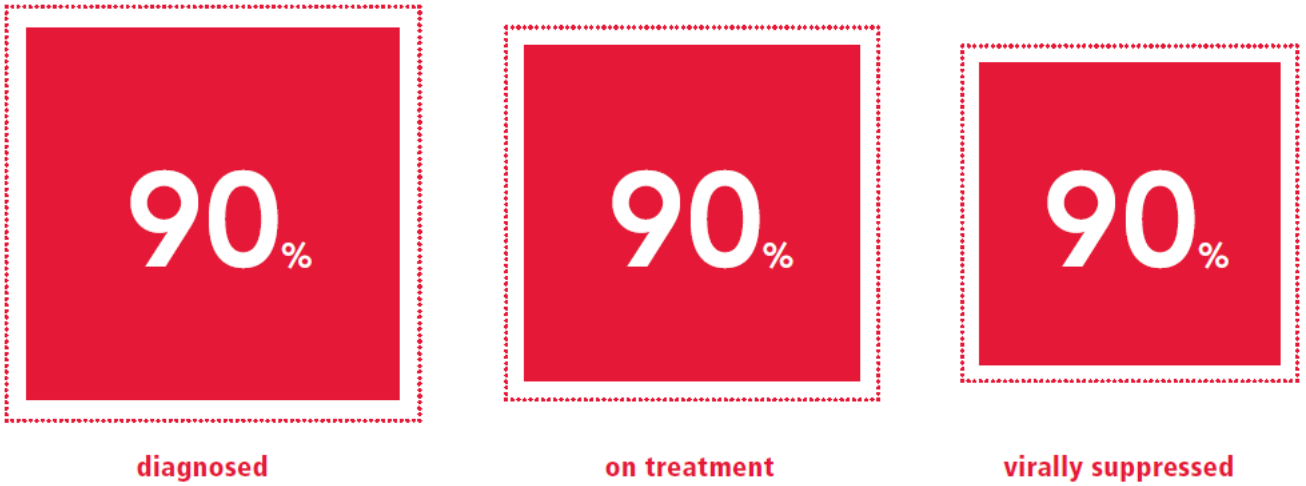
No statistical difference
- By sex
- By study arm

Those who link the least:
- <30 years
- Students
- DNK HIV-pos in the family
- No history of referral
- Distance to clinic >1km

DISCUSSION & CONCLUSIONS

What is the contribution and limits of a strategy starting by home-based HIV testing to reach the first 90 and ultimately the 90 x 90 90 UNAIDS targets?

Discussion & Conclusions (1)



- **Home-based HIV testing has clear advantages and provides benefits**
  - Well accepted by this population **(>77 %)**
  - Allows the re-identification of HIV+ individuals previously diagnosed but not in care (never before or who dropped momentarily)

→ **An efficacious intervention** that will **maximize** the number of PLWHIV aware of their status and is **likely to be necessary** … **but this is not the magic bullet**

Discussion & Conclusions (2)

- **Home-based HIV testing suffers some limitations**

  - 25 % of the « residents » remain uncontacted

  → **More testing services should be available at any point in time in the community (mobile testing is one of them)**

  - Linkage to HIV care within a reasonable time window remains sub-optimal after repeat home-based HIV testing is offered as a central testing strategy (<40 % within 3 months after referral)

  → **Need to put in place at large scale and evaluate a comprehensive combination of interventions proven independantly to contribute to the 90 X 90 X strategy (mobile telephones and SMS reminders, community health workers and peer navigators, home-based ART initiation, …)**

World Health Organization

GUIDELINES

GUIDELINE ON WHEN TO START ANTIRETROVIRAL THERAPY AND ON PRE-EXPOSURE PROPHYLAXIS FOR HIV

SEPTEMBER 2015

Ngiyabonga! Merci !

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wellcome trust

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