WEBINAR 5/6

Demand Creation and Communications, Community Engagement and Community Based Monitoring

Thursday 1 October 2020
9am EST/ 3pm UTC

Unitaid
Innovation in Global Health

HIV SELF-TESTING AFRICA INITIATIVE

atlas
Community Engagement and Community-based Monitoring

Cheryl Johnson
WHO Global HIV, Hepatitis, STI Programme
1 October 2020
Community is key for effective HIV testing services

- **Community empowerment and engagement** is essential to HIV testing services (HTS)
  - The 6\textsuperscript{th} “WHO C” for HTS
- **Task sharing** (e.g. lay providers, KP-led services) and community empowerment are WHO recommended
- **Community and peer-led demand creation** strategies are effective for creating demand for HIV testing services
  - Peer-delivered, participatory and community-led approaches, such as using peer educators, community groups and faith-based programmes increase HTS uptake
- **Community-based HIV testing and linkage** strategies are WHO recommended
  - Strategies which deliver in the natural setting of the community – e.g. self-testing, social networks, mobile outreach, churches, bars, workplaces
  - Under-utilized globally but critical and evidence-based ways to achieve high impact and scale-up
## Community-led monitoring strategies and approaches

<table>
<thead>
<tr>
<th>Monitoring model</th>
<th>Monitoring mechanisms</th>
</tr>
</thead>
</table>
| Health Facility Committees (HFCs)    | • A joint committee of community and HCPs collects recipient of care grievances and works with HCPs to address them  
• Regular meetings between HFC members and healthcare providers/decision-makers track progress on the resolution of identified issue |
| Citizen Report Cards (CRC)           | • Metrics for a ‘report card’ are identified through phone interviews and surveys with recipients of care  
• A healthcare facility’s performance is compared to a national standard or a similar facility at externally facilitated meetings of recipients of care and HCPs |
| Community Score Cards (CSC)          | • Communities and HCP develop indicators separately, then agree on a plan for corrective action  
• Progress on the indicators is jointly monitored by healthcare providers and communities in biannual meetings  
• A variation of this methodology is the use of health advocates, who devise action plans to address recipient of care grievances and work with healthcare providers or MOH officials to address them, and track outcomes and resolutions. |
| Community Treatment/Health Observatories | • Systematic, regular collection of quantitative (monthly) and qualitative (quarterly) data by community and recipients of care networks using indicators identified through a pilot or baseline assessment  
• Data are analysed and discussed in multi-stakeholder meetings, where advocacy plans are developed, implemented and tracked  
• In another formulation, recipients of services or HCWs observe gaps in quality and access at facilities and report back to a community health observatory. |

What can community-led monitoring include?

Approaches to community-led monitoring

- **Development, support and strengthening of community-led mechanisms that monitor availability, accessibility, acceptability and quality of services** (e.g. stock outs, user fees, time to receive results); health policy, budget and resource tracking, and monitoring of health financing allocation decisions; and/or complaint and grievance mechanisms.

- **Community-led monitoring of barriers to accessing services** (e.g. human rights violations, including stigma and discrimination and confidentiality; age and gender-based inequities; geographical and other barriers) for purposes of emergency response, redress, research and/or advocacy to improve programs and policies.

- **Tools and equipment for community-led monitoring** (including appropriate technologies).

- **Technical support and training on community-led monitoring**: collection, collation, cleaning and analysis of data; and using community data to inform programmatic decision making and advocacy for social accountability and policy development.

- **Community engagement and representation** in relevant governance and oversight mechanisms.

Local communities gather, analyse and use information on an ongoing basis to improve access to, quality and impact of services, and to hold service providers and decision makers to account.

Community-led monitoring is not the same as routine program monitoring.

Note: Data collection through CLM is not an end in itself, but rather a step in a series of activities that are part of a complete feedback loop to improve health outcomes. Source: Global Fund, 7 August 2020.
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
Questions?

• Contact: johnsonc@who.int
WEBINAR 5/6

Demand Creation and Communications, Community Engagement and Community Based Monitoring

Thursday 1 October 2020
9am EST/ 3pm UTC
WHO IS REACHED BY HIV SELF-TESTING? INDIVIDUAL FACTORS ASSOCIATED WITH SELF-TESTING WITHIN A COMMUNITY-BASED PROGRAMME

PITCHAYA INDRAVUDH, LSHTM
Background

9.6% adult HIV prevalence in Malawi

.15 to 2 million Malawians tested from ’00-’15

90% Diagnosed
71% On ART
61% Virally suppressed

Malawi MoH 2016; UNAIDS 2018
Parent study: community-based HIVST distribution 2016-18

- **Intervention arm**
  - 11 clusters allocated to CB-HIVST
  - Distribution of HIVST kits by community-based distribution agents

- **Control arm**
  - 11 clusters allocated to SOC
  - Continuation of standard of care, with HIV services provided through health facilities.

**Outcomes**
- HIV testing in the last 12 months
- Lifetime HIV testing

**Measurement**
- Cross-sectional surveys at end of implementation
Intervention

- Door-to-door HIVST distribution model with pre-test information and optional post-test support by community-based distribution agents
- Sep 2016 to Jan 2018
- 203 distributors provided 273,729 HIVST kits
- 50% of kits delivered to men
Current study

22 health facility-defined clusters eligible for randomisation

Intervention arm
11 clusters allocated to CB-HIVST
Distribution of HIVST kits by CBDAs

Outcomes
Ever HIV self-testing

Measurement
Cross-sectional surveys at end of implementation

Age group

Sociodemographic: head of household, married, children

Socioeconomic: educational attainment, wealth status

Sexual behaviour: condomless sex in the last three months

Health behaviour: self-rated health status, no. of HIV tests prior to HIVST implementation, household uptake of HIVST
## Results – age group

- Sample included 1055 men and 1456 women
- 45% of men and 40% for women self-tested
- Age group associated with self-testing, with decreasing uptake at higher levels

<table>
<thead>
<tr>
<th><strong>Age group</strong></th>
<th><strong>MEN</strong></th>
<th><strong>WOMEN</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adjusted prevalence ratio (95% CI)</td>
<td>p-value</td>
</tr>
<tr>
<td>16-19 years</td>
<td>1.02 (0.84, 1.22)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>20-24 years</td>
<td>1.2 (1.02, 1.41)</td>
<td></td>
</tr>
<tr>
<td>25-39 years</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>40+ years</td>
<td>0.74 (0.62, 0.88)</td>
<td></td>
</tr>
<tr>
<td>16-19 years</td>
<td>1.12 (0.93-1.33)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>20-24 years</td>
<td>1.15 (0.99-1.34)</td>
<td></td>
</tr>
<tr>
<td>25-39 years</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>40+ years</td>
<td>0.71 (0.6-0.84)</td>
<td></td>
</tr>
</tbody>
</table>
**Results – sociodemographic**

- Household status not associated with self-testing
- Being married and having children associated with self-testing among women

### MEN

<table>
<thead>
<tr>
<th></th>
<th>Adjusted prevalence ratio (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of household</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1.0</td>
<td>0.88</td>
</tr>
<tr>
<td>Yes</td>
<td>0.94 (0.86-1.14)</td>
<td></td>
</tr>
<tr>
<td>Married or living with partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1.0</td>
<td>0.93</td>
</tr>
<tr>
<td>Yes</td>
<td>0.99 (0.82-1.20)</td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1.0</td>
<td>0.09</td>
</tr>
<tr>
<td>Yes</td>
<td>1.18 (0.97-1.43)</td>
<td></td>
</tr>
</tbody>
</table>

### WOMEN

<table>
<thead>
<tr>
<th></th>
<th>Adjusted prevalence ratio (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of household</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1.0</td>
<td>0.39</td>
</tr>
<tr>
<td>Yes</td>
<td>0.94 (0.8-1.09)</td>
<td></td>
</tr>
<tr>
<td>Married or living with partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1.0</td>
<td>0.002</td>
</tr>
<tr>
<td>Yes</td>
<td>1.26 (1.09-1.46)</td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1.0</td>
<td>0.01</td>
</tr>
<tr>
<td>Yes</td>
<td>1.38 (1.08-1.76)</td>
<td></td>
</tr>
</tbody>
</table>
Results – socioeconomic

- Higher educational attainment and wealth status associated with self-testing among women, with increasing uptake at higher levels

### MEN

<table>
<thead>
<tr>
<th>Household wealth status</th>
<th>None</th>
<th>Primary</th>
<th>Secondary or higher</th>
<th>Lowest</th>
<th>Middle</th>
<th>Highest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational attainment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>1.18 (0.94-1.48)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary or higher</td>
<td>1.30 (0.99-1.69)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lowest</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle</td>
<td>1.1 (0.93-1.31)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest</td>
<td>1.18 (1.0-1.39)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Adjusted prevalence ratio (95% CI) p-value*

### WOMEN

<table>
<thead>
<tr>
<th>Household wealth status</th>
<th>None</th>
<th>Primary</th>
<th>Secondary or higher</th>
<th>Lowest</th>
<th>Middle</th>
<th>Highest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational attainment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>1.31 (1.09-1.57)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary or higher</td>
<td>1.66 (1.29-2.13)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lowest</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle</td>
<td>1.08 (0.92-1.26)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest</td>
<td>1.3 (1.12-1.52)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Adjusted prevalence ratio (95% CI) p-value*
## Results – sexual behaviour

- Recent condomless sex associated with self-testing among men

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Adjusted prevalence ratio (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEN</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condomless sex in last</td>
<td>No</td>
<td>1.0</td>
<td>0.02</td>
</tr>
<tr>
<td>three months</td>
<td>Yes</td>
<td>1.37 (1.06-1.76)</td>
<td></td>
</tr>
<tr>
<td><strong>WOMEN</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condomless sex in last</td>
<td>No</td>
<td>1.0</td>
<td>0.19</td>
</tr>
<tr>
<td>three months</td>
<td>Yes</td>
<td>1.21 (0.91-1.61)</td>
<td></td>
</tr>
</tbody>
</table>
Results – health behaviour

- Health status not associated with self-testing
- Frequent HIV testing prior to HIVST distribution and household uptake of HIVST associated with self-testing

**MEN**

<table>
<thead>
<tr>
<th></th>
<th>Adjusted prevalence ratio (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-rated health status</td>
<td>Poor/fair</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>1.19 (0.95-1.49)</td>
</tr>
<tr>
<td></td>
<td>Very good</td>
<td>1.20 (0.94-1.53)</td>
</tr>
<tr>
<td>Number of HIV tests</td>
<td>0</td>
<td>1.0</td>
</tr>
<tr>
<td>prior to HIVST distribution</td>
<td>1-2</td>
<td>2.01 (1.59-2.54)</td>
</tr>
<tr>
<td></td>
<td>3-5</td>
<td>2.29 (1.8-2.9)</td>
</tr>
<tr>
<td>Household uptake of HIVST</td>
<td>No</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>2.09 (1.8-2.43)</td>
</tr>
</tbody>
</table>

**WOMEN**

<table>
<thead>
<tr>
<th></th>
<th>Adjusted prevalence ratio (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-rated health status</td>
<td>Poor/fair</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>1.08 (0.9-1.29)</td>
</tr>
<tr>
<td></td>
<td>Very good</td>
<td>1.17 (0.95-1.44)</td>
</tr>
<tr>
<td>Number of HIV tests</td>
<td>0</td>
<td>1.0</td>
</tr>
<tr>
<td>prior to HIVST distribution</td>
<td>1-2</td>
<td>2.03 (1.52-2.71)</td>
</tr>
<tr>
<td></td>
<td>3-5</td>
<td>2.51 (1.89-3.34)</td>
</tr>
<tr>
<td>Household uptake of HIVST</td>
<td>No</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1.77 (1.56-2.01)</td>
</tr>
</tbody>
</table>
Summary

- Uptake of HIVST was higher among men (45%) than women (40%)
- Proportion of self-testing was lowest among adults aged 40 years and older
- Women who were married, had children, had higher levels of education or were wealthier were more likely to self-test
- Men who reported condom-less sex in the last 3 months were more likely to self-test
- Frequency HIV testing prior to HIVST distribution and household HIVST uptake were associated with self-testing
Relevance for demand creation

- HIVST attractive for certain under-tested and high-risk sub-groups
- Implementation can be still be optimised to improve uptake among adults ≥40 years and infrequent testers
- Role for community sensitisation and demand creation activities to address ongoing barriers to HIVST and engage more resistant testers
- Perceived sexual risk a motivating factor for HIVST uptake and could be used in messaging
- Knowledge of HIV testing and self-testing process also a strong motivating factor
Who is Reached by HIV Self-Testing? Individual Factors Associated With Self-Testing Within a Community-Based Program in Rural Malawi

Pitchaya P. Indravudh, MA,a,b Bernadette Hensen, PhD,c Rebecca Nzawa, BS,b Richard Chilongosi, BEd,d Rose Nyirenda, MSc,e Cheryl C. Johnson, MA,f Karin Hatzold, MD,g Katherine Fielding, PhD,h Elizabeth L. Corbett, FMedSci,b,c and Melissa Neuman, ScDh
WEBINAR 5/6

Demand Creation and Communications, Community Engagement and Community Based Monitoring

Thursday 1 October 2020
9am EST/ 3pm UTC
USING USER-CENTERED APPROACHES FOR HIVST DEMAND CREATION

Su Balasubramanian
SENIOR MARKETING ADVISOR
OCTOBER 1, 2020
OVERVIEW

- Keystone Program Development Framework
- User-Centered Approaches
THE USER IS ALWAYS AT THE CENTER
Keystone Design Framework

1. DIAGNOSE
2. DECIDE
3. DESIGN
4. DELIVER
STAR COUNTRIES
USER-CENTERED APPROACHES

SEGMENTATION & ARCHETYPES

JOURNEY MAPPING

IDEATION

PROTOTYPING
INSIGHTS ARE ALWAYS EVIDENCE-BASED
SEGMENTATION & ARCHETYPES

Segmentation allows us to divide up the population into groups that we can prioritize and target our messaging and communications specifically to meet their needs.

Archetypes allow us to bring our segments to life and to see them as real people rather than a statistic. It allows us to design specifically for address their barriers in their contexts.
Client Archetype: **Surviving Themba**

Name: Themba
Age: 24
Gender: Male
I live in: Rural
I work as: a multitude of things, piece jobs around the community
I have: several family members including my parents
I am: in a relationship but have multiple other partners
For fun: I like to hangout at the local ‘games’ spot

**Surviving Themba’s Narrative**

Most likely to be living in rural, did not complete his schooling. He had to drop out in order to “be a man” and help his family make ends meet.

Themba helps out the house by tending to the farm, collects firewood and does some piece jobs in the community to help with money in the house e.g. help at the barber shop, sells goods at the market etc.

He has some dead time during the day when he cannot work the farms because of the blazing sun, so he sometimes spends this time with his friends at the local games hangout or plays and watching soccer if he is not visiting his girlfriend.

**Psychographic Profile**

**Attitudes and risk:**

“I work all day… and I have needs, when I come back from work I have the urge to meet with a woman to release all this tension I have inside of me.”

- He holds traditional views on relationships and believes men are more superior
- He believes earning some income suggests one is ready to have a wife.
- He considers himself to be a catch for women as he has an income.
- Cannot say no to girls that throw themselves at him.
- Perceived risk is from his side - he cannot fathom the idea that a woman would cheat on him, as he is a catch
- Does not have it in him to stick to 1 partner and takes the women as a symbol for status and respect.

**Condoms:** Seldom uses condoms as he fears they may “slip off”. He admits no one has taught him how to use a condom and is too embarrassed to ask and does not embarrass himself in front of a girl.
Surviving Themba

HIV Perceptions: A positive result will diminish their ability to work and earn an income. It will not only compromise their health, but power and status that comes with the ability to provide.

HIV testing behaviour: Most likely to be a first time tester, avoids the clinic as a day off work influences their earning potential. Partners status is proxy for their own. Don’t believe their partner can cheat on them.

Recognised ST Value: Convenience - time, Private

Drivers for rejection: Credibility - Kit it too simple looking. The independent nature of this threatens to expose low levels of education

Key Touchpoint in the journey: Demonstration - Offers an opportunity to display one does not need an education in order to be able to successfully conduct the test - interactive leave behind that one can refer to when administering the test in private.

Behavioral Profile

Testing Journey

1. Awareness Most likely to respond to physical cues of one feeling unwell, tiredness etc. Less likely to confide in family and those around him and wont ask for information.

2. Experience Will often travel to a clinic where he is less likely to meet people that may recognize him.
   - ST is collected from the home of the distributor and test is conducted in isolation.
   - In the event of a reactive kit, one is less likely to go back to the distributor for support.

3. Linkage Less likely to link up immediately. Some denial, delayed acceptance of the result and only link to care when one starts to display physical symptoms. More likely to present as a new case at facility and go through testing process all over again. File is kept at facility far from home.

Key Insights

- Wants to “preserve public social public capital – pride and social admiration. Wants to be in control, therefore being seen at the testing facility will bring about judgement to his social persona. Also, Testing at the facility makes one lose power and control of information and confidentiality
- Benefit of HIVST – helps one to manage who accesses results, when and how. Self-Testing gives one end-to end control of the process
JOURNEY MAPPING

- What are the key steps of the journey at each stage?
- What are the key barriers and motivators at each stage?
- Who are the key influencers at each stage?
- What do the 5As look like at each stage?
### 5As

<table>
<thead>
<tr>
<th>Market</th>
<th>Characteristic</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accessibility</td>
<td>Easy to obtain</td>
</tr>
<tr>
<td></td>
<td>Appropriate Design</td>
<td>Meets his needs</td>
</tr>
<tr>
<td></td>
<td>Affordability</td>
<td>Is not blocked by cost</td>
</tr>
<tr>
<td></td>
<td>Assured Quality</td>
<td>Meets his quality expectations</td>
</tr>
<tr>
<td></td>
<td>Awareness</td>
<td>He knows what is out there and how to obtain and use it</td>
</tr>
</tbody>
</table>
Journey Map

Awareness  |  Choice  |  Adoption  |  Continued Use  |  Advocacy

😊  |  😞  |  😊  |  😊  |  😊
DECIDE PHASE

Constraints & Barriers

Opportunities & Objectives
How Might We?

Once you identify interesting insights and design opportunities, we use the How Might We (HMW) format to prompt for potential solutions.

A properly framed How Might We doesn’t suggest a particular solution, but gives you the perfect frame for innovative thinking in a variety of ways.

How: open, not closed
Might: not should!
We: inclusive
? a question, not an answer
IDEATION

BRAINSTORM

SHARE

BUILD
A prototype is a tangible representation of an idea.

It’s low resolution and often not very pretty.

It’s just a starting point - a learning tool for getting feedback from your users and essentially co-creating a solution with them.
testing prototypes & prototyping plans

PROTOTYPING REPORT CARD – HIGH RISK MEN

NAME OF PROTOTYPE: ____________________________
NAME OF SEGMENT: ____________________________
BARRIER TO OVERCOME: _________________________
Barrier Intensity:

EXPERIENCE

<table>
<thead>
<tr>
<th>How did it make you feel?</th>
<th>How much did you learn?</th>
<th>How did it make you feel?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surprised</td>
<td>A Lot</td>
<td>Confident</td>
</tr>
<tr>
<td>Anxious</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

After sharing your ideas:

barrier intensity - POST
WEBINAR 5/6
Demand Creation and Communications, Community Engagement and Community Based Monitoring
Thursday 1 October 2020
9am EST/ 3pm UTC
HIV Self-Testing Demand Creation
South Africa

Ndinatsei Mumbengegwi, Marketing & Communications Manager, STAR South Africa
Priority Archetypes

Nandi Nkabinde
South African adolescent

Thembba Dube
South African adult

Thembba “The new tester”

The first time he tested for HIV in a health facility. “I didn’t have knowledge about HIV so I felt intimidated.”

“It was terrifying because I didn’t know what to expect; I was worried about having to change my lifestyle if my test result came out positive.”

SELF-TESTING

More privacy
Lack of counseling
Control over result disclosure
Personal time to process results

Accuracy of result dependent on user
“You may not get accurate answers. You might think that you’ve done the correct thing, but you didn’t.”

More concern for mental health distress following a positive result

Potential to facilitate partner testing
“I can test with my partner. Our men don’t want to go to the clinic, a lot of them.”

SELF-TESTING

More privacy
Control over result disclosure
No wait time
Personal time to process results

Linkage to care dependent on individual
“There is also a possibility of keeping your positive HIV test a secret and not seek advice. Counseling before an HIV test is important.”

Greater risk for mental health distress after a positive result
No training on use of self-tests
<table>
<thead>
<tr>
<th>Archetype</th>
<th>Barrier/Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age:</strong></td>
<td>Fear of judgement, stigma and discrimination</td>
</tr>
<tr>
<td>&gt; 24</td>
<td>Fear of a positive result</td>
</tr>
<tr>
<td><strong>Gender:</strong></td>
<td>Awareness of HSS</td>
</tr>
<tr>
<td>Fluid</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Archetype</th>
<th>Barrier/Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age:</strong></td>
<td>Accessibility</td>
</tr>
<tr>
<td>&gt; 24</td>
<td>Fear of judgement, stigma and discrimination</td>
</tr>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
</tr>
<tr>
<td>Man</td>
<td></td>
</tr>
<tr>
<td><strong>Maybe married but enjoys having sex with other men</strong></td>
<td>Awareness of HSS</td>
</tr>
<tr>
<td><strong>Identifies as a gay man</strong></td>
<td></td>
</tr>
</tbody>
</table>
Journey Mapping HIVST

Opportunities

Transgender/MSM
- Awareness of HIV ST
- Accessibility

AGYW
- Awareness of HIV ST
- Willing to get tested for HIV
- Has product knowledge

Older Men
- Willing to test for HIV
- Has product knowledge
- Awareness of HIV ST

Sex Worker
- Willing to get tested for HIV

Barriers

Transgender/MSM
- stigma
- Fear of positive result
- Fear of judgement

AGYW
- Won’t accept the kit in public

Older Men
- Accessibility
- Fear of positive result

Sex Worker
- Fear of a positive result
- Fear of stigma
- No time to go to healthcare facility

Contemplation

Fear of being judged when accessing services
“HIV testing has been turned into an intimidating and formidable process through the way that campaigns have depicted it”

“People procrastinate to distract themselves as a way of regulating their emotions such as fear or failure. This feeling is amplified with things that scare us, like the daunting thought of getting tested for HIV.”

“This feeling manifests in the habit of putting off important, less pleasurable tasks by doing things more familiar. Socialising, Facebook, Chores etc.”

“What if we could add the screening process to that list of familiar little daily things?”
## Ideation

### Strategic territory:

**MAKE HIV SCREENING LESS INTIMIDATING AND MORE RELATABLE TO DAILY LIFE...**

### Communication blueprint:

<table>
<thead>
<tr>
<th>Roles for Communication</th>
<th>Channel Palette</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Awareness &amp; Consideration</strong></td>
<td></td>
</tr>
<tr>
<td><em>Testing is no longer a big deal – “Remove the barriers”</em></td>
<td>▪ Community Radio</td>
</tr>
<tr>
<td><strong>Encourage and remind</strong></td>
<td></td>
</tr>
</tbody>
</table>
| *Get a test and test yourself – “who to call or where to find it”* | ▪ Community Activations  
▪ Digital marketing channels |
| **Educate**                               |                                                      |
| *About the kit & how to use it 3 easy steps* | ▪ IEC material  
▪ Print media  
▪ Community based activation  
▪ Digital media channels |
Brand Story & Purpose

The Core 4 Summary Brief

**The Brief in a Tweet:**
Encourage and increase awareness and usage of HIV Self-screening amongst the target population

**Consumer Insight:**
Self-screening for HIV is intimidating/daunting

**Brand purpose:**
To make self-screening for HIV feel as easy as can be

**Creative Ambition:**
Create a breakthrough but relatable campaign that convinces the target population to self screen for HIV
Phased Communication Strategy

1. Create HIVST awareness among target groups

2. Educate on effective HIVST kit use

3. Inform about product accessibility
Phase 1: Creating Awareness
Communication Concept

BIG IDEA
Life for our target audience is daunting enough without the spectre of HIV self-screening. Let’s communicate that HIV self-screening is nothing more than any other chore you do every day.

OUR DREAM
Consumers experience the ease of getting the kit and self-screening for HIV in privacy.
Creative Execution

Check your status. You decide when and where.

It's as easy as 1.2.3.

Check your status. It's as easy as putting on this t-shirt.

HIV SELF-SCREENING
1. 2. 3. SCREEN KNOW ACT.
Check your status.
You decide when and where.
It’s as easy as catching a taxi.

Check your status.
You decide when and where.
It’s as easy as catching a taxi.

Check your status.
You decide when and where.
It’s as easy as uk’khomb’itaxi.
Phase 2: Educate on Product Usage
Communication support for Distribution

- Communications training and support for all models:
  - Community based distributor
  - Peer educators (key populations)
  - HCWs distributing HIVST kits

- Kit use & demonstration tools
  - Instruction videos in 3 languages
  - Instruction steps banner/runner
  - Pre-Screening tool
  - Appointment cards
  - Post-test services insert
HIV SELF-SCREENING FAQs

1. Testing was easy - is it really to be trusted to self-fund and deliver?

   - There is no known risk of infection from self-testing.
   - Self-testing kits are FDA approved.
   - The HIV self-test results are accurate and reliable.

2. Testing is easy - do I need to consult a healthcare provider?

   - The test can be done at home and results are available in a few minutes.
   - Results can be shared with a healthcare provider for further assessment.

3. Testing is easy - will this test show results in a timely manner?

   - Results are available immediately after taking the test.
   - You will receive your results within 20 minutes.

4. Testing is easy - do I have to return the test kit?

   - No, you do not have to return the test kit.
   - The test kit is one-time use and should be disposed of properly.

Remember:

A-positive result needs to be confirmed through additional testing at a health care facility.

DO YOU KNOW YOUR HIV STATUS?

INSTI is another self-screening kit that you can use to find out your HIV status in private and at your own time!

The INSTI HIV Self-Testing Kit:

- Results in 2 minutes
- Easy to use
- No blood sample
- No nurse involved
- Quick turnaround time

Screening yourself is important to your health, your life choices, your health and your future. HIV self-testing is one of the ways that you can get to know your status.
Phase 3: Accessibility
Digital Marketing Campaign

OBJECTIVE:
Lead generation for HIVST kits through digital platforms to increase access for:
- Transgender (TG) and
- Men who have sex with Men (MSM)
- Young women (YW)
- Older men (OM)
Online order and home delivery of HIVST

Step 1: Online reach on social media platforms
- View HIVST advertisement
- Click on advert that diverts to ordering platform
- Self-identify HIV testing needs (self-screening)

Step 2: Online test order
- Fill out online HIVST delivery order (home delivery)

Step 3: HIVST kit delivery
- HIVST kits delivered to clients within 48 – 72 hrs
- Client confirms receipt via social media/followup call

Step 4: Follow-up HIVST
- Perform HIVST, using instructions-for-use and/or video
- If client gave permission to follow-up, feedback provided to distributors telephonically
- Client that didn’t not to be contacted were not followed up
Creative Execution
Online User preferences:

Users by time of day:

<table>
<thead>
<tr>
<th>Time of Day</th>
<th>Users</th>
<th>Last 90 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 am - 9 pm</td>
<td>130</td>
<td>100</td>
</tr>
<tr>
<td>11 am - 12 pm</td>
<td>70</td>
<td>40</td>
</tr>
<tr>
<td>12 pm - 1 pm</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>2 pm - 3 pm</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>3 pm - 4 pm</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>4 pm - 5 pm</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>5 pm - 6 pm</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>6 pm - 7 pm</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>7 pm - 8 pm</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>8 pm - 9 pm</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>9 pm - 10 pm</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Districts where awareness for HSS has been done:

1. Gauteng
2. Western Cape
3. KwaZulu-Natal
4. Eastern Cape
5. Free State
6. Limpopo
7. Mpumalanga
8. North West

Acquisition:

<table>
<thead>
<tr>
<th>Device Category</th>
<th>Users</th>
<th>New Users</th>
<th>Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile</td>
<td>5,735</td>
<td>5,725</td>
<td>6,571</td>
</tr>
<tr>
<td>Desktop</td>
<td>394</td>
<td>386</td>
<td>551</td>
</tr>
<tr>
<td>Tablet</td>
<td>112</td>
<td>112</td>
<td>128</td>
</tr>
</tbody>
</table>
Online Distribution Results

Online distribution for Quarter 2 by Sex, Age and Testing frequency (N=3,759)

- 34% of first time testers are female
- 28% of first time testers are male

Age groups:
- 15-19: 12%
- 20-24: 16%
- 25-29: 11%
- 30-34: 10%
- 35-39: 8%
- 40-44: 8%
- 45-49: 5%
- Over 50: 8%
Online Distribution Results

Online distribution for Quarter 2 by HIVST Kit Type, age, and sex
Contact

DR. KARIN HATZOLD
Director Unitaid/PSI HIV Self-Testing Africa (STAR) Project
khatzold@psi.org
WEBINAR 5/6

Demand Creation and Communications, Community Engagement and Community Based Monitoring

Thursday 1 October 2020
9am EST/ 3pm UTC
ATLAS project: Involving key populations in design, implementation and uptake of HIVST in West-Africa
Juliette BASTIN, Advocacy & Communication Manager

STAR HIV Self-Testing Symposium Webinar Series
October 1st, 2020
### Epidemiological context in WCA

#### A generalised epidemic at a relative low level
(HIV prevalence: 0.4 to 3.8%)

#### Concentrated epidemics among key populations: MSM, FSW, DUs

**In 2018, in the world**
- 37.9 million people are living with HIV

<table>
<thead>
<tr>
<th>Status</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV know their status</td>
<td>79%</td>
</tr>
<tr>
<td>People who know their positive status have access to treatment</td>
<td>78%</td>
</tr>
<tr>
<td>People on treatment have an undetectable viral load</td>
<td>86%</td>
</tr>
</tbody>
</table>

*Source: UNAIDS Data 2019*

**In West and Central Africa**
- 5 million people are living with HIV

<table>
<thead>
<tr>
<th>Status</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV know their status</td>
<td>64%</td>
</tr>
<tr>
<td>People who know their positive status have access to treatment</td>
<td>79%</td>
</tr>
<tr>
<td>People on treatment have an undetectable viral load</td>
<td>76%</td>
</tr>
</tbody>
</table>

*Source: UNAIDS Data 2019*

Hard to reach/hidden population: priority for 1\textsuperscript{st} 90 gap
ATLAS project in a nutshell

- **Outcome**: Increased access to HIV self-testing and linkage to confirmatory testing and treatment among target populations
- **Expected impact**: Reduction in morbidity and mortality due to HIV/AIDS

**Unitaid funded project**

- Mid 2018 ➔ End of 2021
- More than half million HIVST kits to be distributed
- Solthis and IRD consortium with **27 implementing partners & 20 research and technical partners**

**Côte d’Ivoire**: 6 regions, 12 health districts, 32 public / community health facilities

**Mali**: 5 regions, 29 health districts, 30 public / community health facilities

**Sénégal**: 3 regions, 15 health districts, 21 health facilities
ATLAS delivery channels

Primary distribution
HIVST for personal use

- STI patients
- MSMs
- FSWs
- Drug users

Secondary distribution
HIVST to be redistributed to social networks

- Partners of PLHIV - partners of STI patients
- MSM peers and sexual partners
- FSW peers and sexual partners, clients
- Drug users peers and sexual partners

Mixing facility and community-based, primary and secondary HIVST distribution
Main HIVST strategies and activities to create demand among KP

- **Community based HIVST distribution with focus on secondary distribution:**
  - Integration within community prevention and testing activities (activities in hot spots, e.g. brothels, bars, hotels) and social events
  - Peer to peer/social network distribution
  - Home visits
  - Mobile clinics

- **Facility based HIVST primary and secondary distribution:**
  - KP clinics (public and community led) and drop in centers
  - PLwHIV consultations (index testing/secondary distribution only)
ATLAS HIVST distribution so far

Cumulative HIVST distribution trend per country
July 2019 - Aug 2020

ATLAS project
Creation demand strategy
Tools and adaptation

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SENEGAL</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>MALI</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>COTE D'IVOIRE</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>17</td>
<td>33</td>
</tr>
</tbody>
</table>

15,135
36,096
54,719
105,950
ATLAS HIVST distribution so far

HIVST distribution per target population
July 2019 to August 2020

- FSW, peers & partners: 66,061
- MSM, peers & partners: 25,230
- PLwHIV partners: 4,520
- STI patients & partners: 5,401
- DU, peers & partners: 4,738
Demand creation: three targets, decision makers, prescribers and KP

**Decision-makers:**
Implementation, integration into national testing strategies and effective deployment of HIVST in the 3 project countries and in the WCA.

**Dispensing agents:**
Promotion of the integration of a complementary testing tool to achieve first 90 and fill the gap.

**HIVST users:**
HIVST appropriation, uptake and dissemination
Community engagement and demand creation: ATLAS project context

- ATLAS project targets specifically key and at high HIV risk populations:
  - Context of stigmatization/criminalization => discrete approaches
  - Specific channels, messages and materials
  - Not to create demand among the general population
Community engagement in designing and implementing HIVST strategies

- 27 implementing partners from and for key populations
- KP partners active participation
- Large baseline study to the design of tailored awareness-raising tools among KP
- Validation of all messages, media and channels to TWGs
- Focus group
- Cognitive and reiterative interviews with KP
Community engagement in designing and implementing HIVST strategies

**Conception**
Scenario review and validation by TWG before creation of the first version

**Dissemination**
Dissemination via WA groups and social networks

**Motion Design**

**Test**
With target populations

**Adaptation**
Adaptation from the feedback and translation into local languages

ATLAS project
Demand creation strategy
Tools and adaptation
Promote KPs uptake and demand to HIVST

There is a peer MSM who is at the university, I gave him two HIVST. I don't know what happened there but my phone just rings. All the MSM at the university want it.

Peer-education: the role of the PE is one of the most impacting tools for adherence to ADVIH

There was one of my pair, it's been...eight years I work there, she never wants to get tested. I called her, I say now there's another strategy that's come up. [...] She says, “As it's at home, I will make it. So I want you to make it with me. When she finished, we looked, there were two lines. She said, "No, I can't go to the hospital in Abidjan here, but I'm going to Bangolo with my friend, so you give me two. She called me, she said, my friend also did that, two lines appeared". Last night she called me, they went to the health center, they are on ARVs.
Promote KPs uptake and demand to HIVST

And then in addition to the hotline there, you can have your information sheets, your leaflets in front of you and then you call and while you call, you look at all that there, it's even easier.

Dispensing support tools: posters, flyers, complementary brochure, national flip charts on testing

...This is due to the comfort of the test, because there are 5 printed materials at our disposal, you can not have any difficulty to do this test. What appealed to me the most is the fact that it's free. With these 5 supports, it's really easy to use.
Promote KPs uptake and demand to HIVST

With HIVST you can get a lot of hidden people. We send them the video and explain the test to them, and they accept.

I did the self-test awareness. I created a WhatsApp group. There was also the possibility of friends adding other friends. In the group, I talked about HIVST, how to dispense. Whoever is able to take the self-test, we give each other an appointment. If he sees that he has other partners that he can give to, I also give him for his partners.

Audiovisual, digital materials: ATLAS website, demonstration video in local languages, Motion design spot, Social networks, WA groups

With HIVST you can get a lot of hidden people. We send them the video and explain the test to them, and they accept.
Promote KPs uptake and demand to HIVST

You do the demonstration and then ask him to do the demo. When you see that everything is correct, there are no worries, he can leave. If afterwards he says he has a little problem, he calls hotline and it's very simple.

When you give it to someone, there is a hotline and it is available. So whether the person makes a feedback or not is up to that person. But they can call the hotline if they need the correct reading of the test result or to know where to go.

Ruban Rouge hotline, Côte d'Ivoire

CTA hotline, Sénégal
Adaptation of demand creation tools

The tools will be evaluated and revised to meet the needs of the beneficiaries

- Use of monitoring and evaluation data
- Focus groups with dispensing agents and users
- Evaluation mission and adaptation of the tools to their needs
- Exploitation of research data

Focus groups with peer-educators in Mali
Upcoming highlights for HIVST KP distribution

2nd wave awareness based on evaluation feedback

MTV Shuga Babi – season 2

Private sector

Support for the adaptation of tools in the WCA within the framework of FM grants

COVID-19 context
Some pictures have been taken before COVID19 outbreak. All our partners and teams have been equipped with individual protective equipment.
WEBINAR 5/6
Demand Creation and Communications, Community Engagement and Community Based Monitoring

Thursday 1 October 2020
9am EST/ 3pm UTC
HIV SELF-TESTING AFRICA

Monitoring social harms in key populations in Malawi
Nicola Desmond
LSTM
Demand Creation and Communications, Community engagement and Community based Monitoring,
1st October 2020
Malawi background – HIV & sex workers

- Current population 17.5 million (2019)
- HIV prevalence 10.6% adult population
  - Incidence highest in women aged 15-34
  - Prevalence highest in women aged 25-29 (13.6%)
- Prevalence highest in Southern Malawi (14.6%, 2019)
- Total national sex worker population 36,700
- HIV prevalence in Sex workers 62.7%

PEPFAR report Malawi 2019, MPHIA 2016
Sex worker policy, regulatory & service context

- KP mentioned as priority group in health strategy documents BUT no targeted national services
- Sex work ‘legal’ but brothels and payment for sex illegal
- Until 2016 law of ‘vagabondage’ used to control sex work
- Sex worker services provided through NGOs limited by funding and time constraints
  - Linkages project – working with local NGOs providing SH services including condom distribution, STI services, FP services through drop-in centres
HIVST results SW

- Highly mobile & seasonal
- Migratory patterns commonly link urban, plantations and lakeside
- Perceptions of sex work as temporary work
- Overall 10,000 kits to be distributed through local NGO: Pakachere
- Actual distribution 5,281 by 25 PE 57% to SW aged 15-24
- Venue-based SW greater likelihood of accessing HIVST

Blantyre
3,183

Mulanje
(tea estates)
254

Chikwawa
(sugar estates)
565
HIVST delivery for SWs

Of those 1,344 HIV+ of 4,096 kits returned (only 33%)
Only 61 FSW linked to care for first time
Unknown first-time versus repeat testers
BUT high retesting rates for those with prior knowledge of their HIV positive status and on ART
BUT likely known HIV+ re-testing to ‘confirm’ current status
Tracking linkage was also likely underreported as FSW used aliases at ART services, frequently attended non-Pakachere services, and were highly mobile.
AIM: To investigate appropriate HIVST delivery models among FSW and monitor unintended social harms

Street-based SW model
Pilot intervention: HIVST
Facility-based SW model

Staggered recruitment
150 street / 150 facility

Audio computer assisted self-interview: 300
Enrolment qualitative biographical interview: 40

socio-demographics, sexual behaviour, testing history, social harms

3 months
Daily sexual behavior/social harms
Weekly HIV testing behaviour

Pictorial diary study

Data collection March – December 2017
Longitudinal Pictorial Diary Study

Daily reports of sexual partners, condom use and social harms per partner.

Weekly reports of HIV self and facility based testing and coercion to test or disclose test result.

Note: For each person that you had sex with today, please complete one row.

Note: Please ANSWER the question about HIV testing EVERY WEEK. If ‘YES’ to this question, COMPLETE row ‘1’ if you ‘self-tested’ this week OR row ‘2’ if you tested for HIV at a facility OR row ‘1’ AND ‘2’ if you had both.
### SW key findings

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>16-25</td>
<td>151(57.0)</td>
</tr>
<tr>
<td></td>
<td>26-35</td>
<td>96(36.2)</td>
</tr>
<tr>
<td></td>
<td>&gt;36</td>
<td>18(6.8)</td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td>Primary or less</td>
<td>170(64.2)</td>
</tr>
<tr>
<td></td>
<td>Secondary or higher</td>
<td>95(35.8)</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td>Married or living as married</td>
<td>77(29.1)</td>
</tr>
<tr>
<td></td>
<td>Never married</td>
<td>96(36.2)</td>
</tr>
<tr>
<td></td>
<td>Widowed or separated</td>
<td>92(34.7)</td>
</tr>
<tr>
<td><strong>Previously tested for HIV</strong></td>
<td>No</td>
<td>35(13.2)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>230(86.8)</td>
</tr>
<tr>
<td><strong>HIVST use in last 3months</strong></td>
<td>No</td>
<td>134(50.6)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>131(49.4)</td>
</tr>
</tbody>
</table>

- High rates of Intimate Partner Violence reported at enrolment (48.4%)
- 29 events of coercive testing
- Power relations between FSWs and PEs and the venue owners often shape HIVST decision-making processes
- 28 forced disclosures between FSW and established intimate partners, family members, peers and peer-distributors
## Regret & relationship problems after HIVST

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>Total</th>
<th>Immediate regret about HIVST</th>
<th>Regret now about HIVST</th>
<th>Relationship problems caused by HIVST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>%</td>
<td>p-value</td>
<td>%</td>
</tr>
<tr>
<td>Test initiator</td>
<td>Self</td>
<td>87</td>
<td>12.6</td>
<td>0.20</td>
<td>9.2</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>44</td>
<td>22.7</td>
<td></td>
<td>9.1</td>
</tr>
<tr>
<td>HIVST result</td>
<td>Reactive</td>
<td>45</td>
<td>15.6</td>
<td>1.00</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Unreactive</td>
<td>86</td>
<td>16.3</td>
<td></td>
<td>10.5</td>
</tr>
<tr>
<td>Age in years</td>
<td>16-25</td>
<td>66</td>
<td>18.2</td>
<td>0.40</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>26-35</td>
<td>53</td>
<td>11.3</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>&gt;36</td>
<td>12</td>
<td>25</td>
<td></td>
<td>8.3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>131</td>
<td>16.0</td>
<td></td>
<td>9.2</td>
</tr>
</tbody>
</table>

Regrets about HIVST use only available for those reporting HIVST use in last 3 months

Proportion of women reporting regret decreased over time
Important role of PE in access to HIVST

• To support
  • ‘...I cannot read very well and so she was helping me including with interpreting the result’
  • ‘I was doing it and she [PD] was instructing me since I had never done it before’

• BUT also some pressure
  • ‘Aah, I knew I was “fine” [HIV negative] but I didn’t want to disappoint the one that gave me the testing tool. So I just wanted to test and “give” her the result’

• Overall benign influence of social relationships on decisions around testing not perceived as negative but rather as positive encouragement
Some evidence that relationship problems exacerbated if HIVST initiated by someone else

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>Total</th>
<th>Immediate regret about HIVST</th>
<th>Regret now about HIVST</th>
<th>Relationship problems caused by HIVST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>p-value</td>
<td>p-value</td>
<td>p-value</td>
</tr>
<tr>
<td>Test initiator</td>
<td>Self</td>
<td>87</td>
<td>12.6</td>
<td>0.20</td>
<td>3.4</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>44</td>
<td>22.7</td>
<td>9.1</td>
<td>13.6</td>
</tr>
<tr>
<td>HIVST result</td>
<td>Positive</td>
<td>45</td>
<td>15.6</td>
<td>6.7</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>86</td>
<td>16.3</td>
<td>10.5</td>
<td>5.8</td>
</tr>
<tr>
<td>Age in years</td>
<td>16-25</td>
<td>66</td>
<td>18.2</td>
<td>16.7</td>
<td>9.1</td>
</tr>
<tr>
<td></td>
<td>26-35</td>
<td>53</td>
<td>11.3</td>
<td>0</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>&gt;36</td>
<td>12</td>
<td>25</td>
<td>8.3</td>
<td>8.3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>131</td>
<td>16.0</td>
<td>9.2</td>
<td>6.9</td>
</tr>
</tbody>
</table>
Partnership types & HIVST

- Disconnect between trust & risk with "regular clients"
  - "Because we started seeing each other and having sex a long time ago, we have reached a point of trusting each other. Whenever he is coming here, he phones to say “book a room for me”, “cook for me” because we love each other”
  - "There are some, you tell them “Aah here is a condom, put it on” and they say, “I do not wear a condom”. That person is a long-time customer right? It is like we end up referring to them as “‘my plain one”
  - "Some say, “I have a wife so it is not good for me to go with you, better if it was my wife”..."
Greater likelihood of reporting regret if younger

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>Total</th>
<th>Immediate regret about HIVST</th>
<th>Regret now about HIVST</th>
<th>Relationship problems caused by HIVST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>p-value</td>
<td>p-value</td>
<td>p-value</td>
</tr>
<tr>
<td>Test initiator</td>
<td>Self</td>
<td>87</td>
<td>12.6</td>
<td>9.2</td>
<td>3.4</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>44</td>
<td>22.7</td>
<td>9.1</td>
<td>13.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.20</td>
<td>1.0</td>
<td>0.06</td>
</tr>
<tr>
<td>HIVST result</td>
<td>Positive</td>
<td>45</td>
<td>15.6</td>
<td>6.7</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>86</td>
<td>16.3</td>
<td>10.5</td>
<td>5.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
<td>0.54</td>
<td>0.25</td>
</tr>
<tr>
<td>Age in years</td>
<td>16-25</td>
<td>66</td>
<td>18.2</td>
<td>16.7</td>
<td>9.1</td>
</tr>
<tr>
<td></td>
<td>26-35</td>
<td>53</td>
<td>11.3</td>
<td>0</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>&gt;36</td>
<td>12</td>
<td>25</td>
<td>8.3</td>
<td>8.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.40</td>
<td>&lt; 0.01</td>
<td>0.51</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>131</td>
<td>16.0</td>
<td>9.2</td>
<td>6.9</td>
</tr>
</tbody>
</table>

- Greater likelihood of reporting regret if younger.
Daily reporting of social harms

Report of at least one occurrence in day of:
- Economic abuse
- Sexual abuse
- Physical abuse
- Verbal abuse
- Sexual encounter
Results of GEE analysis

<table>
<thead>
<tr>
<th>Type of social harm</th>
<th>Adjusted $^1$ odds ratio (95%CI) For occurrence of social harm in week of test and following week compared to no test</th>
<th>p value (AORs differ)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinic Test</td>
<td>Self Test</td>
</tr>
<tr>
<td>Verbal</td>
<td>1.76 (0.91 – 3.41)</td>
<td>1.73 (1.04 – 2.86)</td>
</tr>
<tr>
<td>Physical</td>
<td>1.53 (0.73 – 3.21)</td>
<td>1.44 (0.83 – 2.52)</td>
</tr>
<tr>
<td>Sexual</td>
<td>1.69 (0.79 – 3.33)</td>
<td>1.43 (0.83 – 2.46)</td>
</tr>
<tr>
<td>Economic</td>
<td>1.62 (0.82 – 3.22)</td>
<td>1.33 (0.78 – 2.25)</td>
</tr>
</tbody>
</table>

- Evidence for an increase in verbal abuse immediately after testing
- No evidence this differs between clinic based testing and HIVST

Analysis using Generalised Estimating Equations (GEE)

$^1$ Adjusted for total sex encounters per week and self identification as sex worker
Conclusions

- Qualitative & quantitative analysis ongoing
- High background rates of all types of violence for SW population
- HIVST no less likely to result in social harms as largely due to result NOT test
- Exploring risk behaviours & social harms linked to partner type
- Potential for HIVST kits to facilitate ‘couple’ testing with regular clients
- Linkage continues to be problematic for SW populations
Acknowledgements

• Moses Kumwenda, Wezzie Lora (MLW)
• Webster Mahvu, Miriam Taegtmeyer, Frances Cowan (LSTM)
• Paul Mee, Melissa Neumann, Liz Corbett (LSHTM)
WEBINAR 5/6

Demand Creation and Communications, Community Engagement and Community Based Monitoring

Thursday 1 October 2020
9am EST/ 3pm UTC