TRUNG TÂM HỖ TRỢ SÁNG KIẾN PHÁT TRIỂN CỘNG ĐỒNG
CENTER FOR SUPPORTING COMMUNITY DEVELOPMENT INITIATIVES

The model of community-based HIV testing in Vietnam

Bangkok, June 23rd 2023

Outline of the Presentation

1. About SCDI and our objectives;
2. Implementation and Findings;
3. Results/Conclusions for the model.

SCDI
Develop Together

Centre for *Supporting Community Development Initiatives (SCDI)*:

- A local NGO in Vietnam, founded in 2010;
- Mission: “Towards an inclusive society in a sustainable planet”;
- Strategic objective #1: by 2030, end HIV transmisison where we work.
- Implementing HIV program with GF support.

Geographical areas:
5 coastal provinces

23 CBOs
(Community-based organizations)
PWID -- SW – MSM - TGW

- **CBO: outreach, HIV-testing, communication, commodities, health service referral…**
- **SCDI: Connect & coordinate activities between local health services & CBOs**

The context of HIV epidemic in Vietnam

- The HIV epidemic in Vietnam is shifting from PWID to MSM/TGW.
- The growth of social networks and lifestyle changes leads to the emergence of new high-risk behaviors (eg, chemsex, substance use).
- The popularity and availability of rapid testing (including self-testing), ART, PrEP... offers many new solutions and opportunities.

National strategy to end AIDS by 2030

95-95-95 Objective by 2030:

- 95% of PLHIV in the community know their HIV status;
- 95% of PLHIV knowing their HIV status receive ARV treatment;
- 95% of people receiving ARV treatment with viral load below the suppression threshold.

The targets for HIV testing:

- The percentage of PLHIV in the community knowing their HIV status will reach 90% by 2025 and 95% by 2030.
- The percentage of people with high-risk behaviors for HIV infection who are tested for HIV every year will reach 70% by 2025 and 80% by 2030.

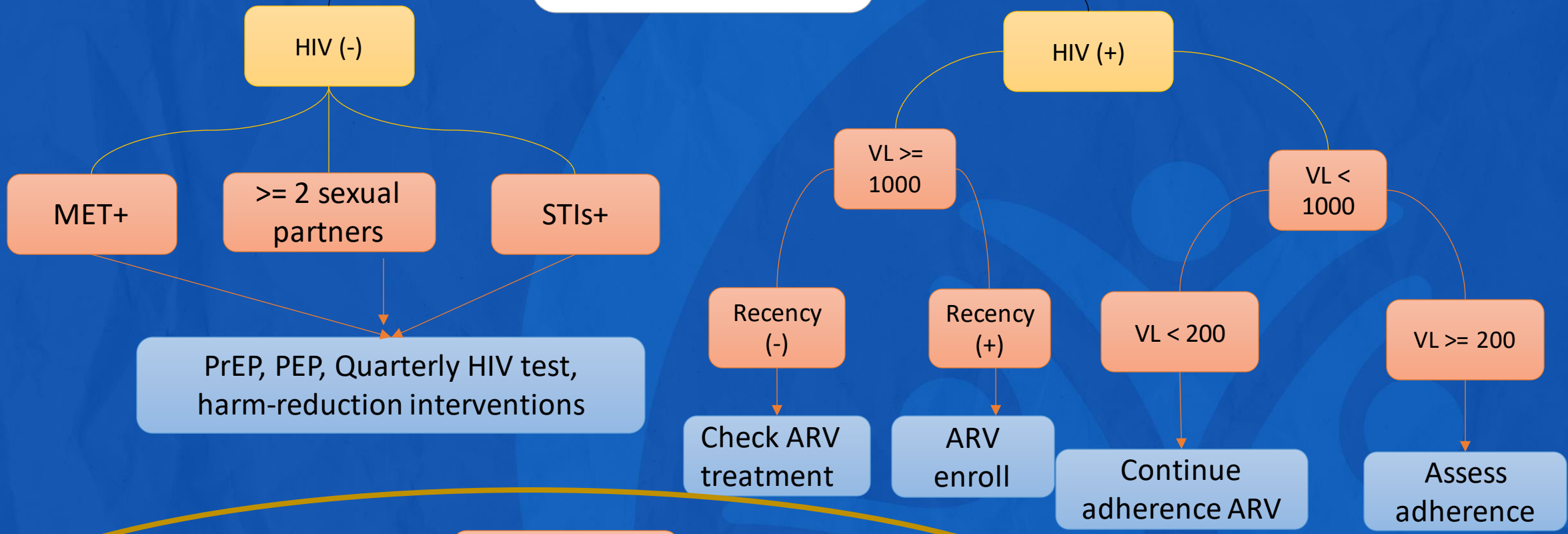
Community –based testing integrated in 2 intervention models:

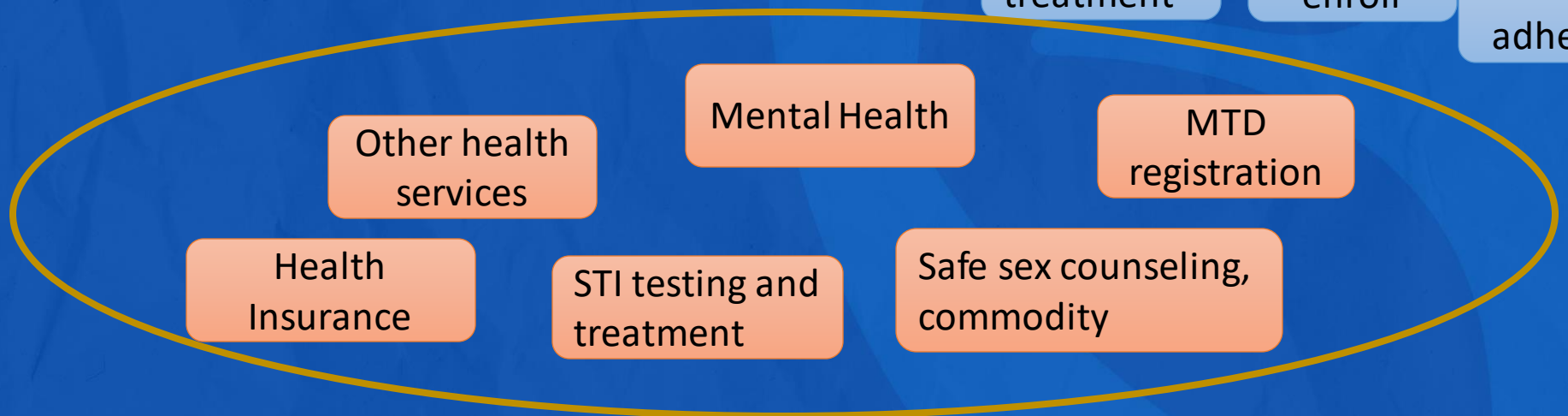
1. **Traditional**
2. **CHEER (***Community-based HIV Epidemiological Evaluation and Response***)**

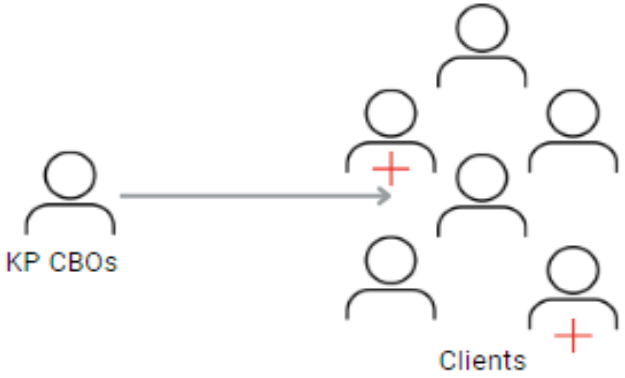
Commonalities:

- HIV testing is 1 of 3 standard service packages that each KP client is offered by PE : BCC messages, health products, and referral to medical services.
- Clients receive pre-test counselling and sign consent form before taking HIV test.

DIFFERENTIATED INTERVENTIONS



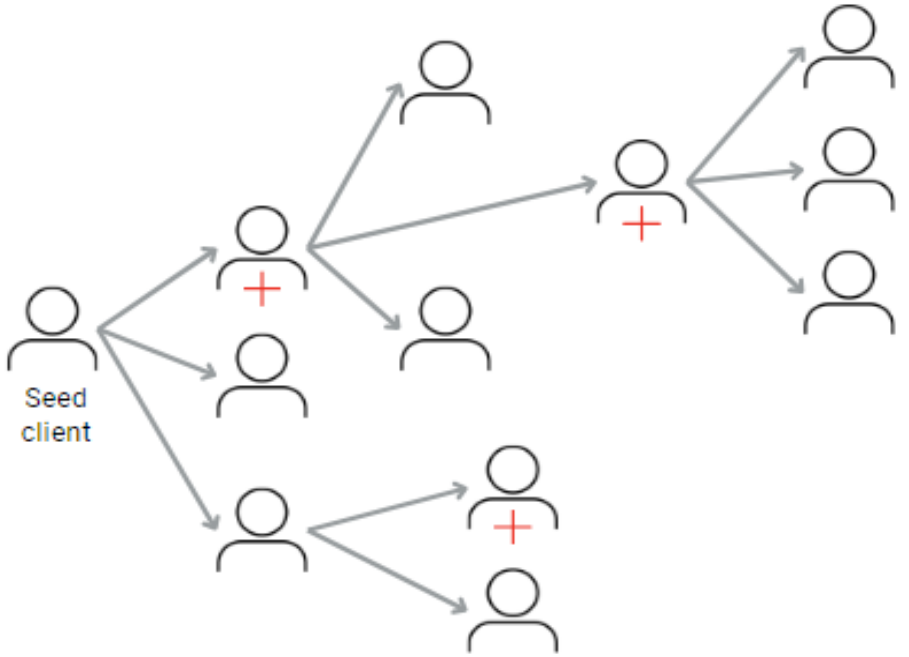




HIV test in Community

- CBO do Laytest, or
- Client does Self-test, or
- Client does self-test with CBO's support

Traditional model



HIV test done in study site by medical technician

CHEER model

\+ CBO referal

Confirmation by CDC

24 hours/7 days

2. Implementation and Findings (1 of 5): TRADITIONAL MODEL

- Implemented from the very first years of the project;
- Peer Educators (PEs) in CBOs provide HIV-testing in the community, where they reach **high-risk KPs who don't know their status;**
- **Apply self-testing or lay-testing**, if positive then referred to a designated lab for confirmation;
- Client recruitment method: **PEs reach out to clients;**
- PEs are paid monthly allowances;
- Effective especially for PWIDs and FSWs in areas where the HIV epidemic under control.

Lay testing

PEs instruct and supervise clients in self-testing at CBO's office

Bome-based testing by PE to client in a mountainous district.

2. Implementation and Findings (2 of 5) : TRADITIONAL MODEL

Advantages

- Friendly/flexible for CBOs, especially for new CBOs; CBO leader can mentor new PEs;
- Effective in reaching PWID and FSWs;
- Promote community outreach work;
- Allow some privacy for the clients;
- Monthly stipend help to have PEs' continued engagement for outreach activities and CBOs;

Disadvantages

- Hard to reach the "most hidden" KPs, b/c they may not want to disclose their behavior, meet strangers (especially, MSM and TGW);
- Uniform approach may not be most suitable for some cases;
- In some areas, there are multiple smaller hotspots, so more effort is needed to reach them;
- Some PWID clients became more complex to reach (poly-drug users, more mental health issues).

2. Implementation and Findings (3 of 5): CHEER MODEL

CHEER model is developed based on DRIVE study. DRIVE (funded by ANRS & NIH) evaluated the effectiveness of a combination of existing HIV interventions on ending HIV epidemic among PWID in low resource setting.

Each Respondent Driven Sampling Survey (RDSS) recruits ~450 PWID within 35 days. The model consists of two stages:

- Stage 1: KNOW THE EPIDEMIC: collect information on local HIV epidemic among the particular KP: prevalence, incidence, viremia, risk factors (STI, sexual behaviors, substance use…).
- Stage 2: TAILOR INTERVENTION to the epidemic at local and individual level (refocus the investment basing on local epidemic, deploy differentiated intervention basing on individual circumstance).
- RDSS is also an effective strategy to recruit clients.

2. Implementation and Findings (4 of 5) : CHEER MODEL

- Started from late 2020 in a number of sites, where epidemiological assessment is required & traditional outreach no longer bring new clients;
- Client recruitment method: **clients recruit new clients** to RDS site, organized by CBOs;
- Medical staff draw venous blood for **100% clients**: once for all the tests: HIV rapid/confirmatory/recency, viral load; and STI tests.
- **Individualized differentiated intervention basing on needs:** HIV status, viral load, risk factors…
- **Retest HIV- high risk clients** for early detection of seroconversion.

Medical staff take HIV tests at the RDS site organized by CBO

Medical staff take HIV tests at the RDS site organized by CBO

2. Implementation and Findings: CHEER Model (5 of 5)

Advantages

- Very effective and appropriate for PWID, MSM, TG especially in areas of high incidence;
- A large number of KPs can be reached in a short time;
- Brings together CBOs and health workers to collaborate on providing services to hard-to-reach KPs;
- Provides full set of services to all enrolled KPs (HIV+ and HIV-); many HIV+ cases who have not enrolled or dropped out of treatment are found and re-connected to treatment;
- Detecting positive cases early by classifying customers by risk and re-testing periodically.

Disadvantages

- Requires engagement of health workers from provincial CDC offices;
- Many high risk KPs are coming to one place at the same time, so there is perception of limited confidentiality, hence less practical for many M
- Some MSM clients don't like venipuncture;
- The organization of RDS depends on the local context and CBO capacity

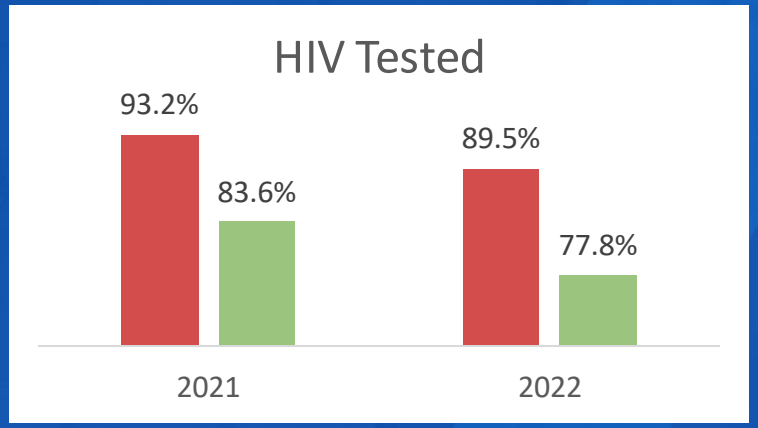
3. Results/Conclusions for the model

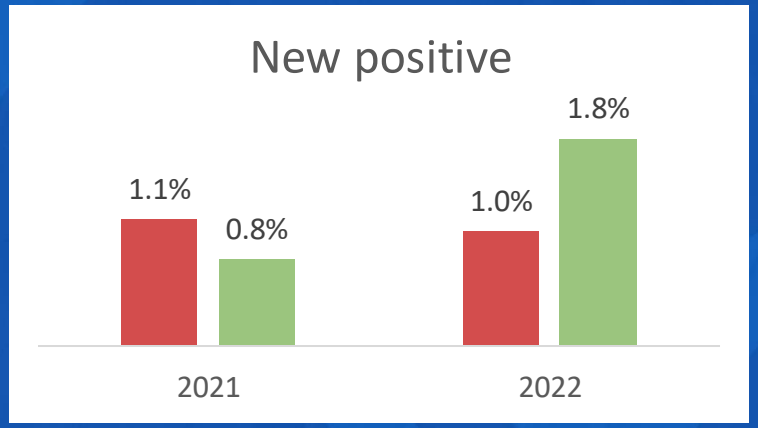
Year	Reached	HTC		New HIV (+)		OPC		ARV	
		#	%	#	%	#	%	#	%
2022	13,136	10,765	82.0%	162	1.5%	152	93.8%	152	100%
2021	11,580	10,094	87.2%	91	0.9%	84	92.3%	84	100%
2020	12,182	8,977	73.7%	170	1.9%	167	98.2%	167	100%

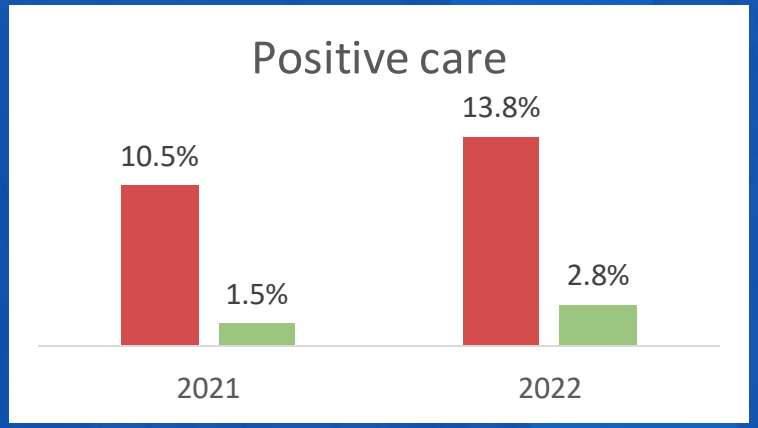
3. Results/Conclusions for the model

		2022			2021		
		Total	CHEER	Traditional	Total	CHEER	Traditional
Reached (1)	n	13,136	4,653	8,483	11,580	4,346	7,234
HIV testing (2)	n	10,765	4,166	6,599	10,094	4,049	6,045
	% (2:1)	82.0%	89.5%	77.8%	87.2%	93.2%	83.6%
Positive care (3)	n	874	640	234	567	458	109
	% (3:1)	6.7%	13.8%	2.8%	4.9%	10.5%	1.5%
New positive (4)	n	162	42	120	91	45	46
	% (4:2)	1.5%	1.0%	1.8%	0.9%	1.1%	0.8%
New positive on ART (5)	n	152	36	116	84	41	43
	% (5:4)	93.8%	85.7%	96.7%	92.3%	91.1%	93.5%
PrEP (7)	n	424	159	265	571	195	376
	% (7:2)	3.9%	3.8%	4.0%	5.7%	4.8%	6.2%

By models


HIV Tested
93.2%
83.6%
89.5%
77.8%
2021
2022


New positive
1.1%
0.8%
1.0%
1.8%
2021
2022


Positive care
10.5%
1.5%
13.8%
2.8%
2021
2022


CHEER
Traditional

3. Results/Conclusions for the model

Year	Local results			CBOs' results			CBOs' contribution	
	# of HTC	# of new positive	Rate	# of HTC	# of new positive	Rate	HTC	New positive
2022	319,322	676	0.21%	10,765	162	1.5%	3.4%	24.0%
2021	320,846	742	0.23%	10,094	91	0.9%	3.1%	12.3%
2020	385,331	756	0.20%	8,977	170	1.9%	2.3%	22.5%

In the past 3 years, the rate of new positive cases detected by community groups has always been higher than the local average. Although the number of annual HIV tests by SCDI CBOs accounted for only 2.3% to 3.4% of the number of local tests, they contributed to the detection of 22% to 24% of new positive cases. This shows the significance of the community-based testing model in reaching and detecting infections in in high-risk populations.

3. Results/Conclusions for the model

- HIV testing and referral by CBOs have so far followed and met the targets of the national strategy.
- Community-based HIV testing reduces barriers and increases access to health care among sensitive and vulnerable groups.
- Each model is suitable for different KPs in specific locations. The flexible application of models helps to find difficult/hidden cases with a high probability of HIV transmission in the community.
- Targeted testing in high-risk populations is more effective in early detection and referral of positive cases rather than testing on a large scale.

SCDI
Cùng Phát Triển

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Thank you for your listening and attention!