

# HIV testing for couples



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# Why test as a couple?

- ➔ In most sub-Saharan African countries, @ 75% of adults are in a cohabiting sexual partnership ('marriage')
- ➔ Most new infections are acquired in marriage
- ➔ Joint testing reduces risk of HIV, STI, and unplanned pregnancy
- ➔ <1% of all couples in Africa counseled and tested together
- ➔ ANC is an opportunity for joint Testing and counseling.



# Example of Kigali, Rwanda

➔ 2003-2006: 3 stand alone centers

- 340 Influence network agents distributed 74,500 written invitations
- 36,900 couples attended with transport reimbursed
- 32,000 tested, 3840 discordant couples identified

➔ Transition from research to practice.....

➔ 2007: USAID funds PSF to train 300 counselors from Kigali government health centers



## By 2008 – Kigali, Rwanda

- ⇒ 40,000 couples tested at Projet San Francisco:
  - half were cohabiting couples,
  - @15% of the city's cohabiting couples had participated
- ⇒ MOH endorsed routine testing of male partners in ANC
- ⇒ Weekend programs set up to accommodate both partners together

## Lessons learned from Kigali, Rwanda

- ➡ 2006-2008: male partners tested separately from wives in government clinics
- ➡ 2009: CDC/NIMH/LSTM procedures adopted as National Guidelines
- ➡ [www.cdc.gov/globalaids/CHCTintervention](http://www.cdc.gov/globalaids/CHCTintervention)
- ➡ Weekend programs in clinics facilitated the transition to integrated weekday services

# Example of Lusaka, Zambia

➡ 2003-2007: 3 stand alone centers operated by (ZEHRP)

- 1600 Influence network agents distributed 144,000 written invitations
- 18,000 couples attended
- 13,000 tested, 2300 discordant couples identified



## By 2008 – Lusaka, Zambia

- ➡ 3 fixed sites closed (NIMH funding ended)
- ➡ 3% of Lusaka's cohabiting couples had been tested
- ➡ transition to weekend programs in ANC clinics;  
target 20% of ANC visitors to bring male partners
- ➡ Couple transport paid, clinic promoters paid a nominal sum (not performance based)
- ➡ Couple transport cut in half, clinic promoter pay reduced—attendance dropped >50%
- ➡ In clinics with no couple transport, <1% of ANC visitors return with partners

# Lessons learned from Lusaka, Zambia

- ➡ Couples' testing still not a social norm, need continued promotions and incentives
- ➡ Sustainability will occur at a social level once enough couples have been tested ( $>15\%$ )
- ➡ Sustainability CANNOT occur if efforts are limited to 'supply side' without support for 'demand side'





## Couples' testing is possible in ANC

- ➡ Successfully implemented in 2001 in 2 ANC clinics in Lusaka and 2 clinics in Kigali
- ➡ No HIV testing was available at the outset, within 8 months >2000 women were tested alone during the week and >1600 women with partners on weekends

# World AIDS Foundation HIV testing Program in antenatal clinics-2001

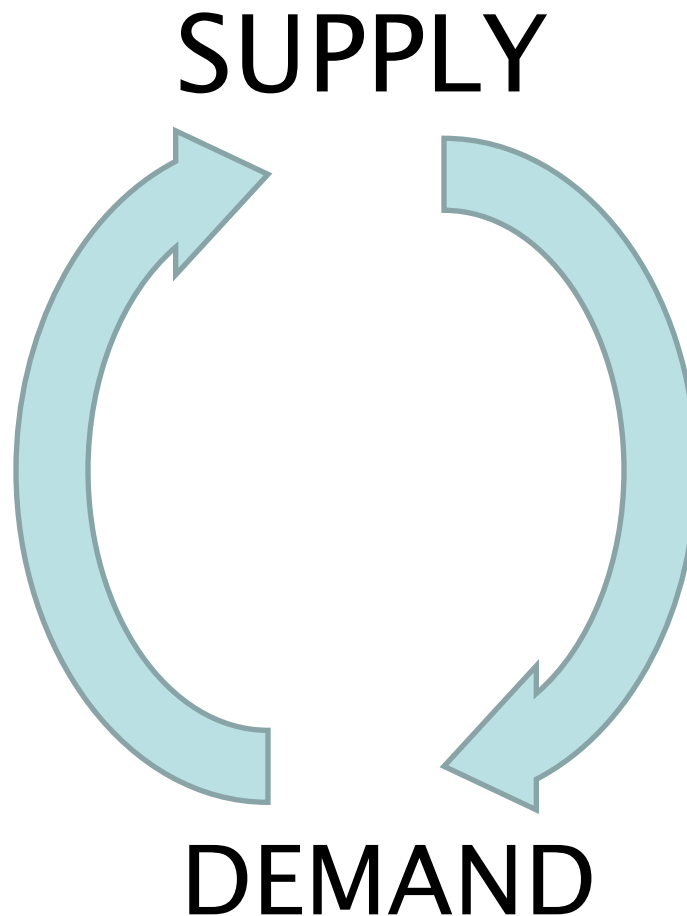
| <b>8 months in 2001</b>       | <b>KIGALI<br/>RWANDA</b> | <b>LUSAKA<br/>ZAMBIA</b> |
|-------------------------------|--------------------------|--------------------------|
| <b>Singles N</b>              | 193                      | 91                       |
| HIV+                          | 21%                      | 22%                      |
|                               |                          |                          |
| <b>Married F tested alone</b> | 791                      | 931                      |
|                               | 14%                      | 27%                      |
|                               |                          |                          |
| <b>Couples N</b>              | 956                      | 663                      |
| HIV + M / HIV + F             | 8%                       | 18%                      |
| HIV - M / HIV + F             | 5%                       | 9%                       |
| HIV + M / HIV - F             | 4%                       | 8%                       |
| HIV - M / HIV - F             | 83%                      | 64%                      |

# Obstacles in CHCT Provision

- ➡ Lack of vision and commitment among funding agencies and policymakers
- ➡ Lack of indicators, mandates, and budgets to incentivize CVCT
- ➡ Re-invention of the wheel with dysfunctional models (ex separate testing, no incentives).
- ➡ Competing messages in clinics and community (e.g. malaria, HAART)
- ➡ Lack of demand resulted in lack of CVCT supply, which in turn discourages demand

# We need to focus on both sides

- Trained couples' counselors
- Accessible services, including weekend and evening
- Stand-alone AND integrated; each plays an important role
- Add partners to antenatal clinic, ARV screening, blood bank, existing VCT



- Active promotion to establish social norm
- Reach 15%–20% of a target audience to achieve 'snowball effect'
- Incentives for couples and promoters may be necessary in the early stages

# Technical assistance available

- ➡ RZHRG is a COE in CHCT with 20+ years of experience
- ➡ Counseled couples and follow-up of >10,000 discordant couples
- ➡ CDC funding RZHRG to provide TA
- ➡ French and English speaking trainers
- ➡ Didactic and practicum training for counselors, Promoters and program managers, Lab techs and Data mangers

# Acknowledgments

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