

Why choose Home Based HTC as a strategy?

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Outline

- **Status of HIV in Kenya**
 - Progress in HTC
- **Prevention impact of HTC/HBTC**
- **Opportunities for HBTC**
- **Operational strategies for HBTC**
- **Conclusion**



National HIV Prevalence by Sex (15-64 years)

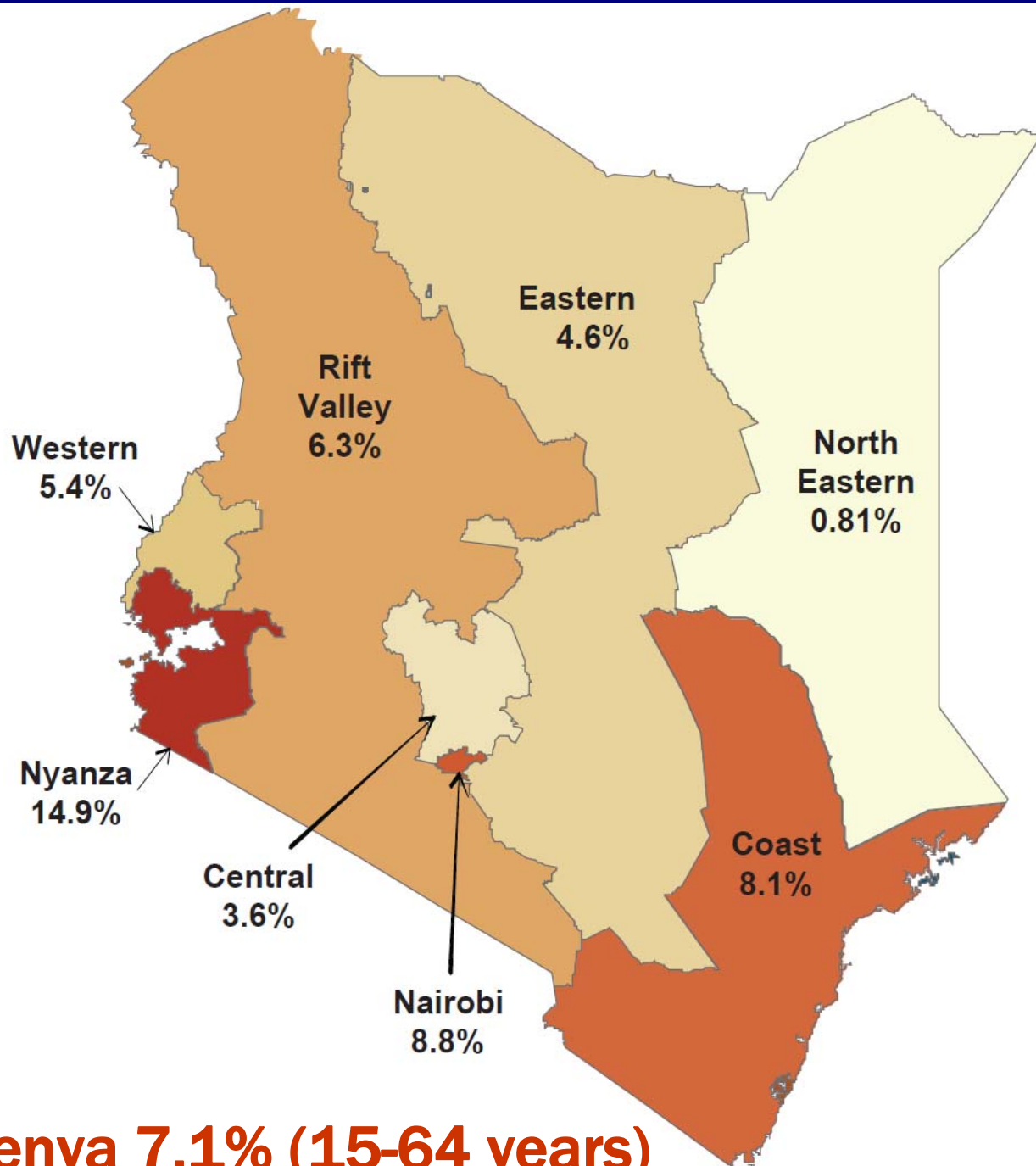
7.1% (1.4 million) Kenyans aged 15-64 living with HIV in 2007

% HIV Infected		
Total	Females	Males
7.1	8.4	5.4



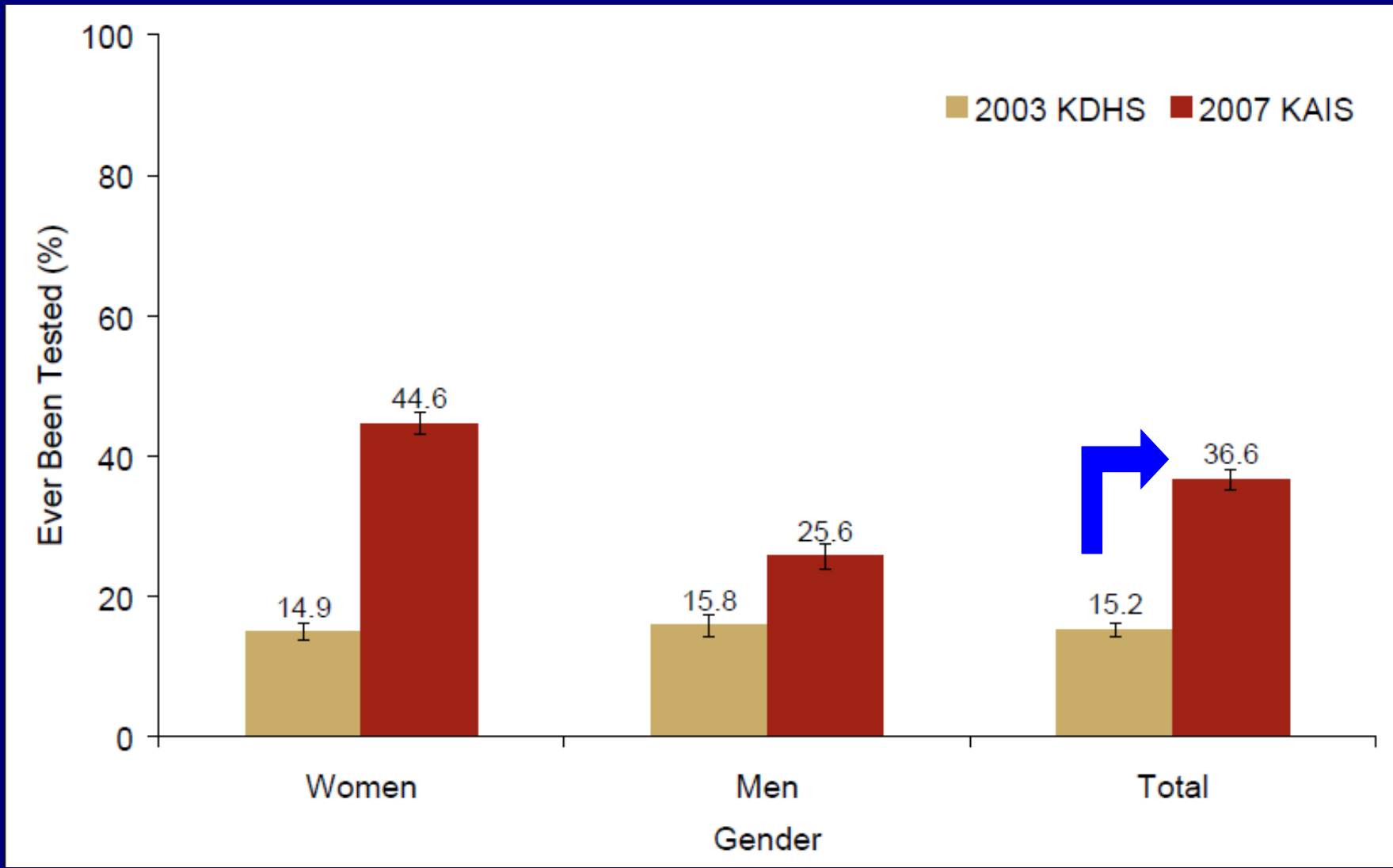
HIV prevalence
ranged from
1% to 15%
across provinces.

Nyanza and Rift
Valley home to
>50% of all HIV-
infected adults
(15-64 yrs)



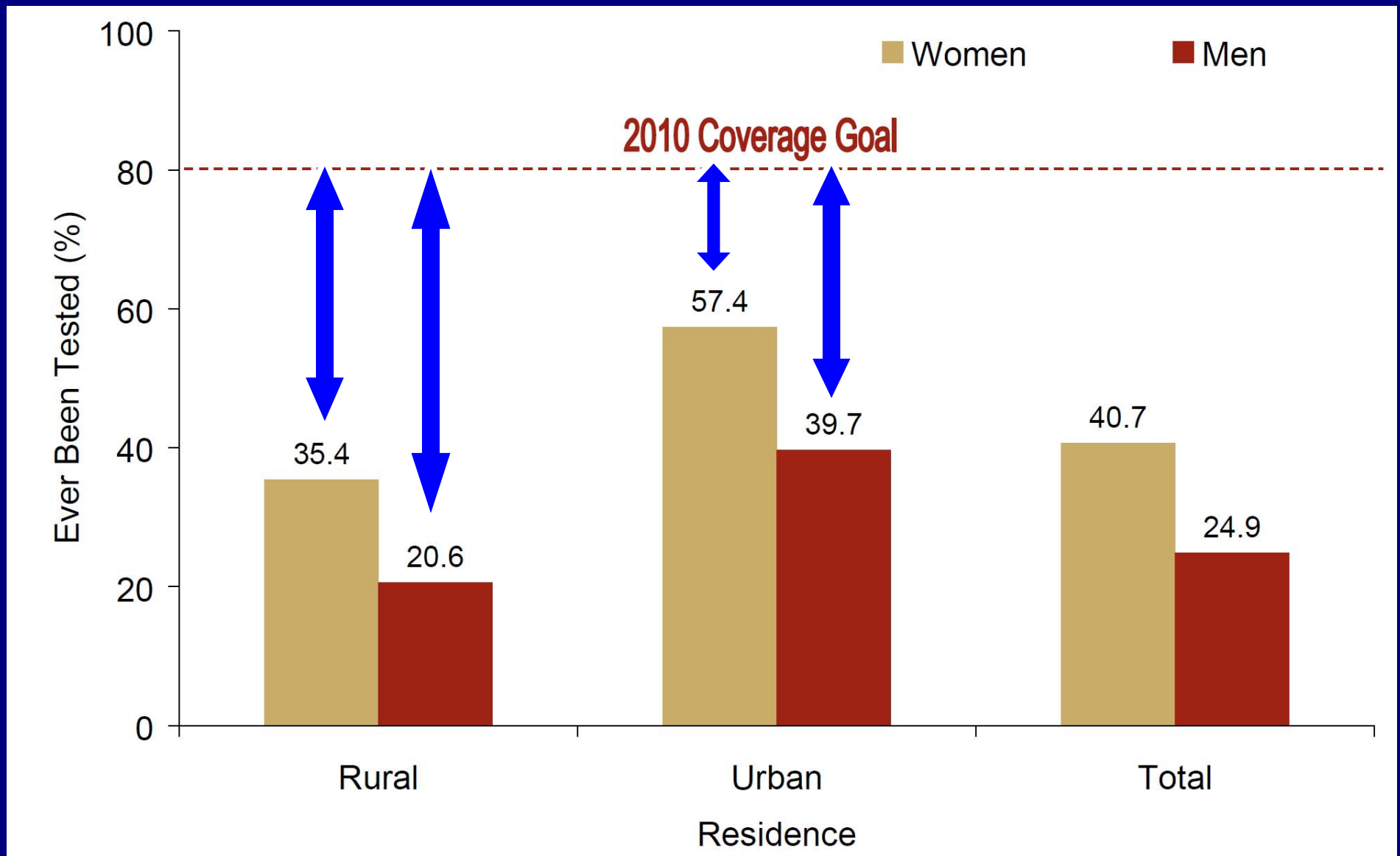
Kenya 7.1% (15-64 years)

Ever Tested for HIV and Received Test Results (15-49 years) 2003 KDHS and 2007 KAIS



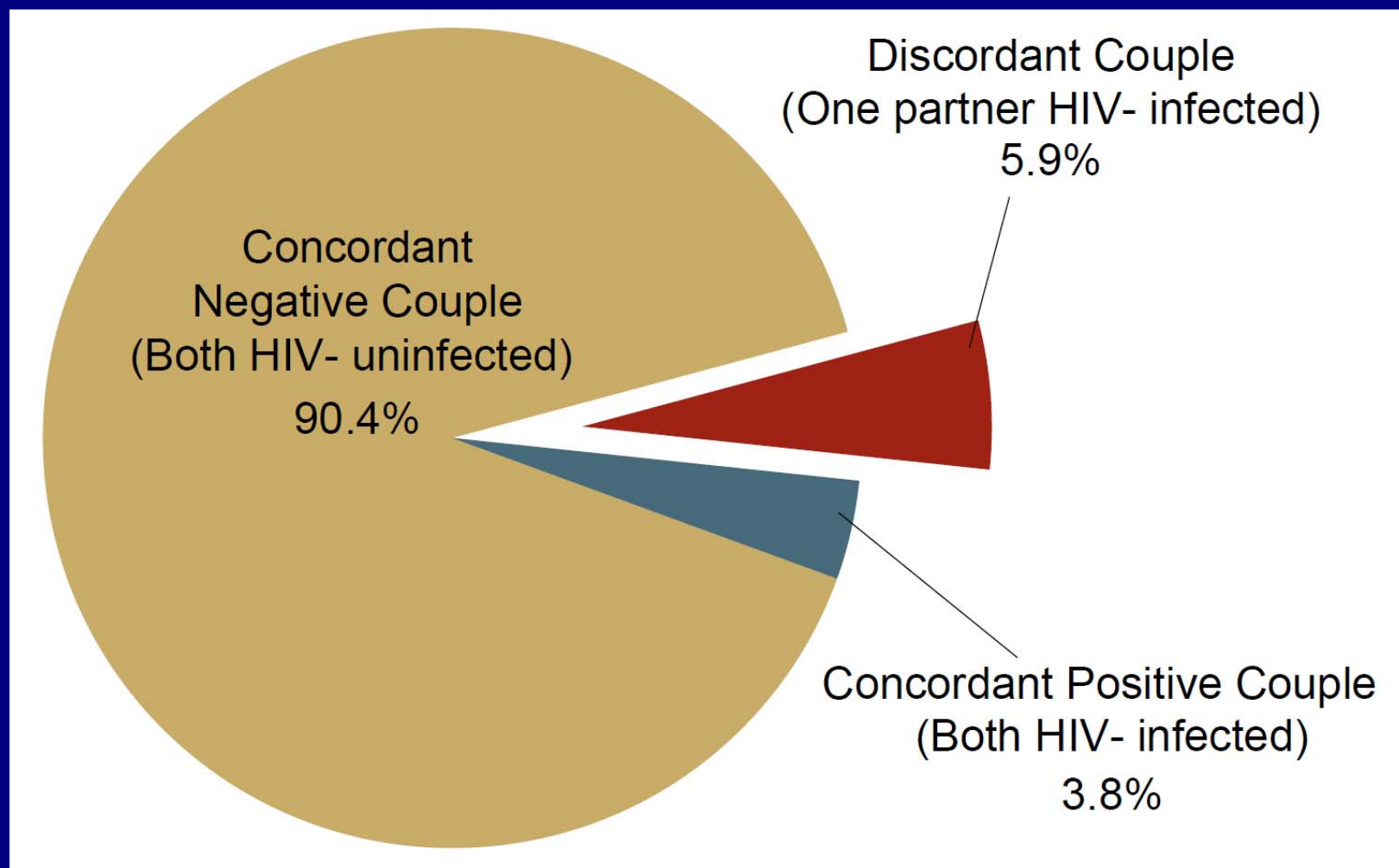
Percent ever tested doubled for men, tripled for women

Gaps in HIV Testing by Sex and Residence (15-64 years)





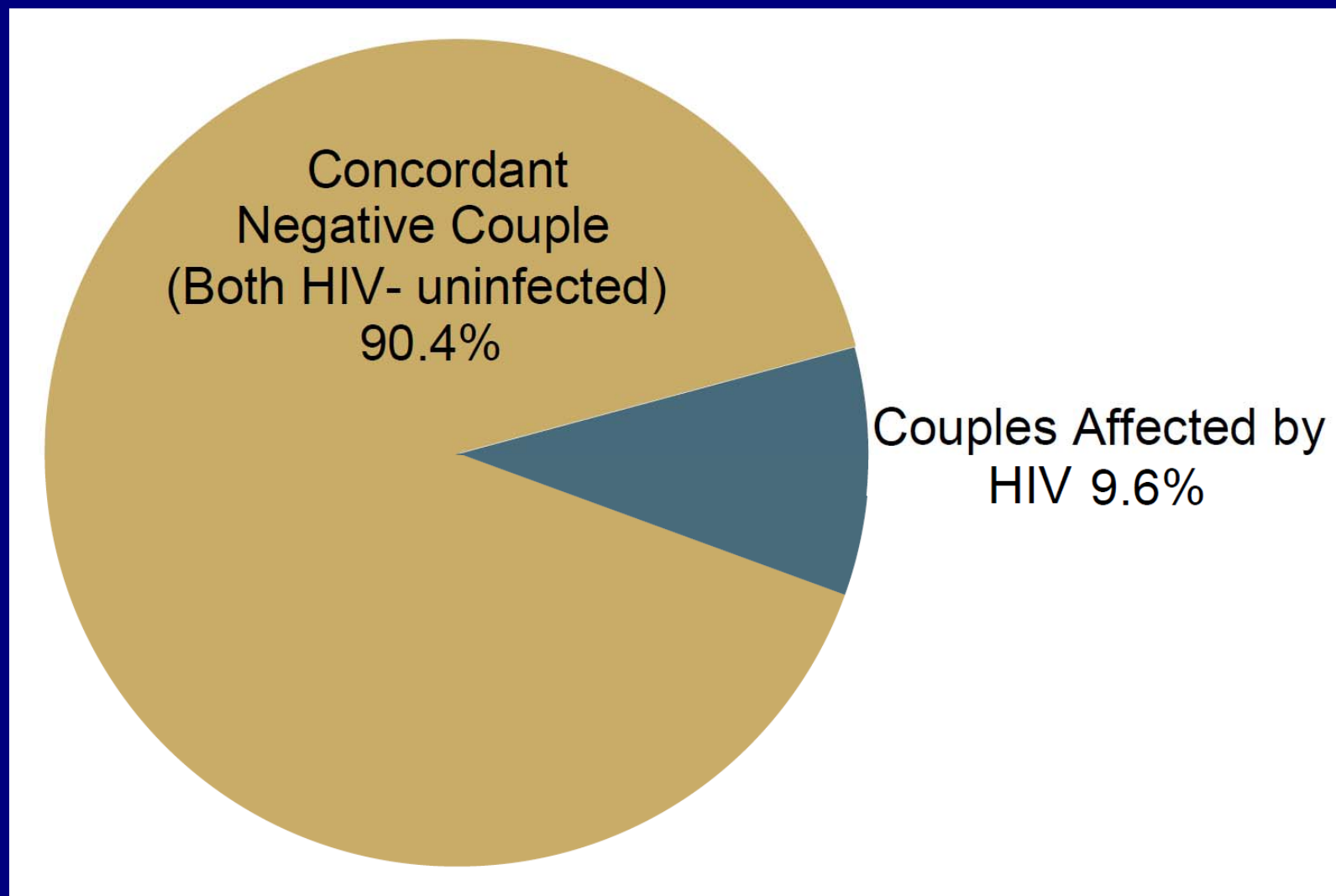
HIV-discordance among Married Couples



>60% of couples affected by HIV are HIV-discordant;
overall, 5.9% discordant.



Married Couples Affected by HIV



1 in 10 married couples affected by HIV

Principles of Combination HIV Prevention



1) Important to “know one’s HIV epidemic”

- HIV prevalence & incidence
- Populations at highest risk
- Whether they know they’re at risk & their HIV serostatus
- Modifiable risk factors (community & individual levels)
- Evidence for different prevention interventions

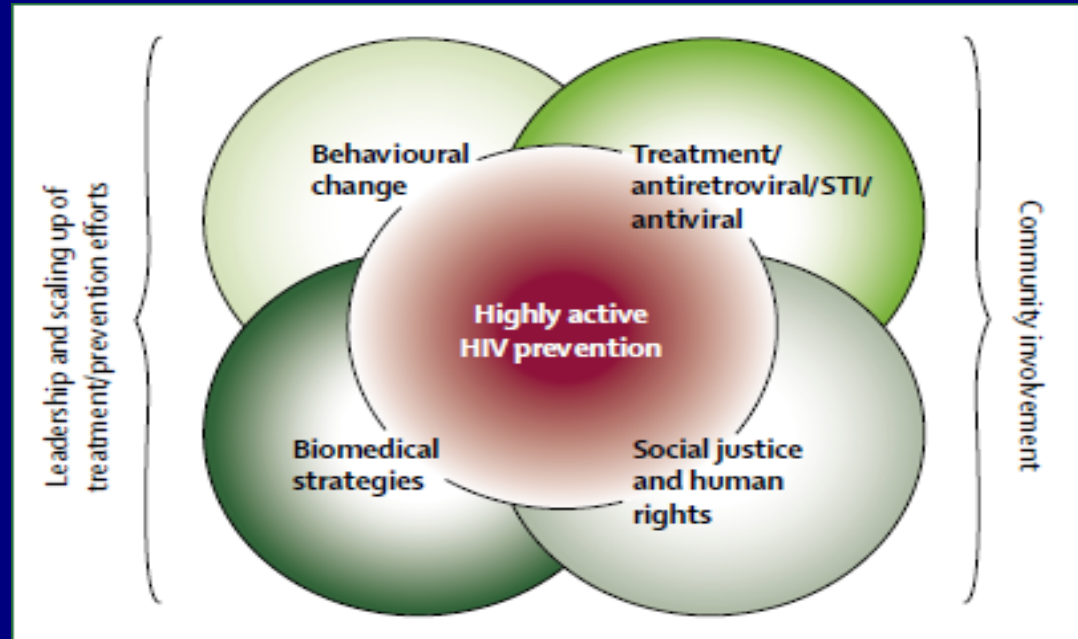
2) To slow HIV epidemic ($R_0 < 1$), need interventions with demonstrated efficacy to reduce infectiousness & susceptibility

- ART for HIV+, MC for HIV- men at high risk (eg., in discordant couples)
- Consider synergy, redundancy & antagonism when combine interventions

3) Consider coverage, efficacy & cost-effectiveness in ‘scaling up’ interventions

“Highly Active HIV Prevention” (aka HARP), or Combination, multi-component HIV prevention

Should be evidenced-based, targeted & integrated...



... not “kitchen sink” with all possible interventions



What Works for HIV Prevention (strong observational evidence)

Intervention	Target	Evidence	Effect for HIV prevention	Comment
Male circumcision	HIV- men	3 RCTs; >30 observational studies	58% reduction	Population-level reduced HIV risk for women in mathematical modeling studies

- “ Large benefits of male circumcision among heterosexual men in low male circumcision, high HIV prevalence settings: one HIV infection being averted for every five to 15 male circumcisions performed, and costs to avert one HIV infection ranging from US\$150 to US\$900 using a 10-y time horizon.” (UNAIDS/WHO/SACEMA, m PLoS Med 2009)
- Indirect benefits of reduced HIV transmission to women
- Additional benefits of reduced GUD, HSV-2 incidence, HPV incidence in circumcised HIV- men and reduced GUD and vaginosis in female partners

What Probably Works for HIV Prevention (strong observational evidence)



Intervention	Target	Evidence	Effect for HIV prevention	Comment
Condom use	HIV- & HIV+, men & women	Multiple observational studies	estimated 80% reduction with consistent use	Less evidence for female condoms
HIV testing as a couple with ongoing couples counseling	HIV serodiscordant couples	Observational cohorts	? >50%	Limited data to quantify efficacy
Treatment of curable STIs	HIV- & HIV+, men & women (pre-ART)	1 positive & 5 flat RCTs; extensive observational data & shedding studies	unknown (38% reduction in positive RCT)	1 RCT demonstrated efficacy, in early-stage HIV epidemic setting
Topical vaginal microbicides particularly 0.5% PRO 2000	HIV- women	-PRO 2000, 1 RCT with 1 RCT ongoing -Tenofovir gel 2 RCTs ongoing	30% reduction not statistically significant	Other microbicides have failed to demonstrate efficacy



What Should Work for HIV Prevention

(observational or preclinical data; clinical trials ongoing)

Intervention	Target	Evidence	Effect for HIV prevention	Comment
PrEP	HIV- men and women	6 RCTs ongoing	unknown	High efficacy in animal model studies
ART provided to HIV+ persons, including "early" treatment at higher CD4 counts	HIV+ men and women	1 RCT ongoing; observational studies in context of CD4<200	observational studies 79-100% reduction	Mathematical modeling:potentially high population effect
VCT	HIV- & HIV+, men & women	1 RCT ongoing	unknown	One RCT demonstrated behavior change with VCT
Treatment of malaria, helminths	HIV+, men & women (pre-ART)	Short-term treatment studies	unknown	Treatment reduces plasma HIV



Rationale

Strategy	Stand-Alone	Hospital	Household member	Door to Door
Cost per client	19.26	11.68	13.85	8.29
Cost per new client	29.70	14.73	14.54	9.21
Cost per HIV infected identified	100.59	43.10	231.65	163.93

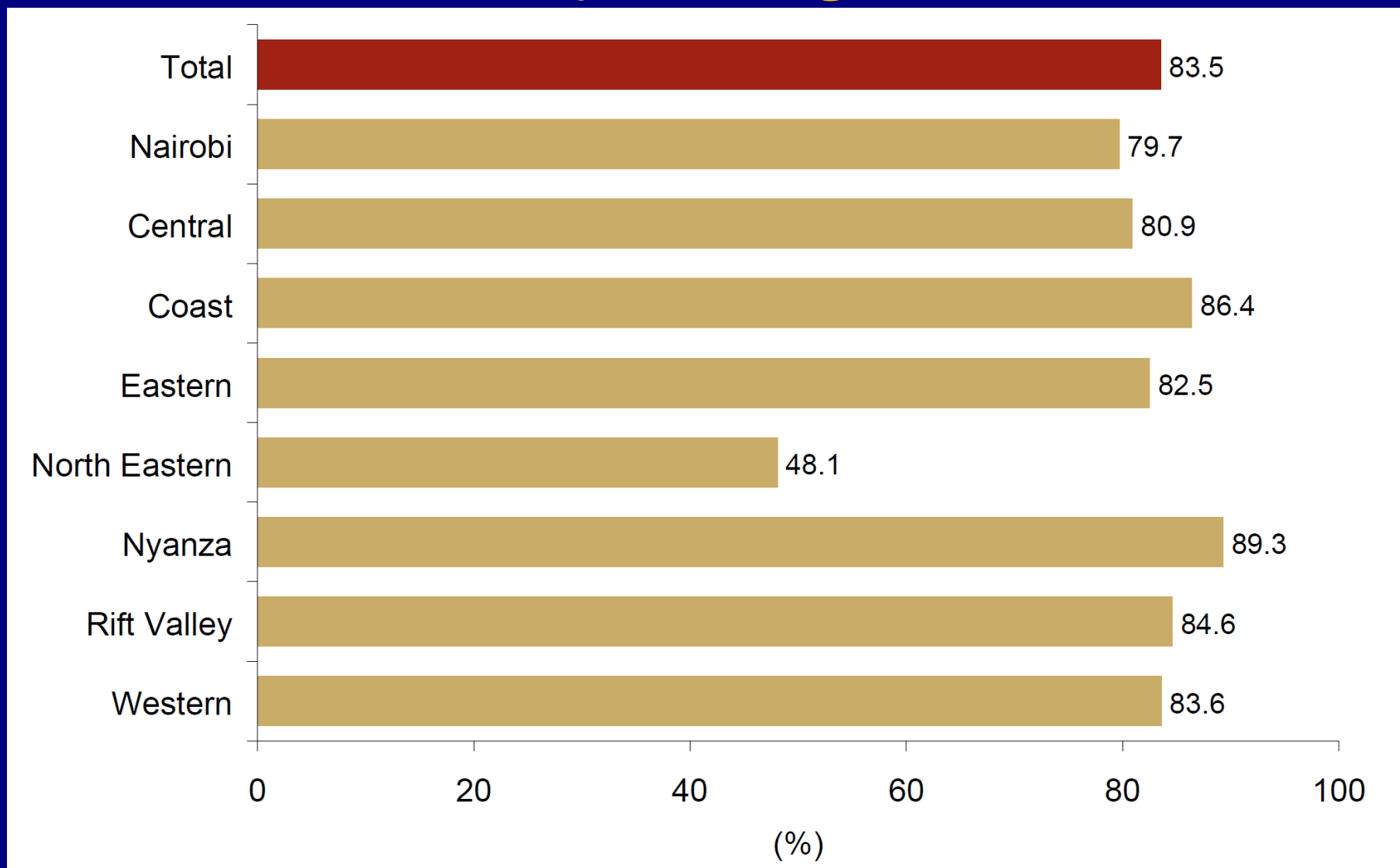


Opportunities for HBHTC



Willingness to Test at Home by Province

83.5% of adults (15-64 yrs) willing to test for HIV at home



Components of Basic Care Package (BCP) for HIV+ persons



Safe water vessel



Chlorine



Filter for H2O



Condoms



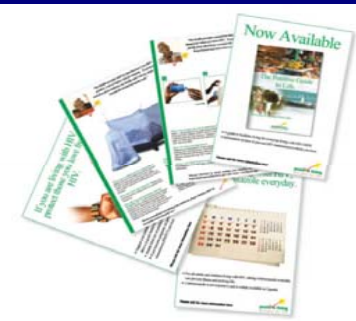
Bednet



Cotrimoxazole Prophylaxis



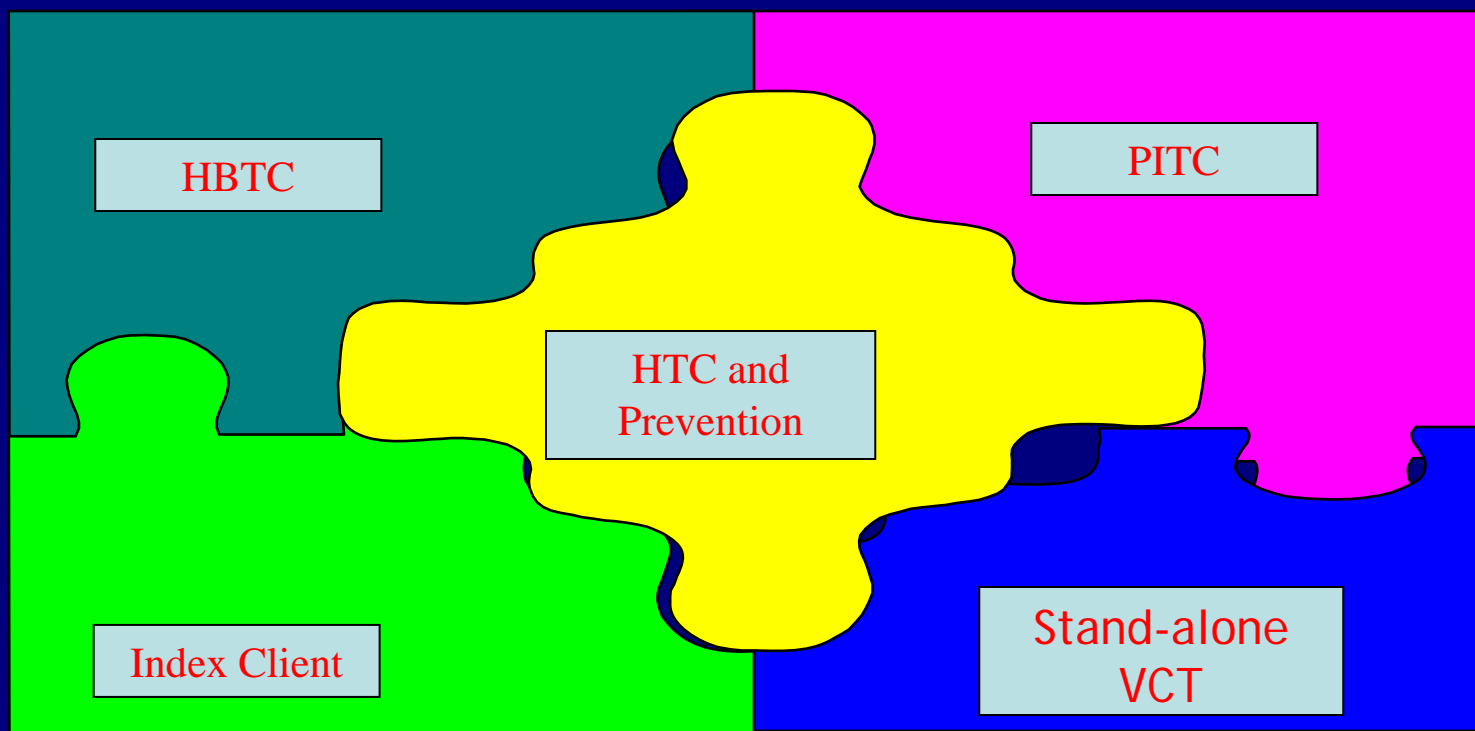
IEC materials



Operational strategies for HBTC



The HTC Jigsaw





The roadmap service delivery strategies

- **Proposes effective strategies for each HTC approach**
 - ✓ **VCT: 80% of time, effort and resources dedicated to outreach services; targeted outreach for MARPs**
 - ✓ **HBTC: district mapping coordinated by DASCOs to facilitate systematic targeting and coverage;**
 - ✓ **PITC: 100%inpatients and 50% outpatients coverage in In high volume districts and facilities, provincial and district; PCR testing for children below 2 years; direct linkages to care and treatment through referrals; task shifting**



HTC strategies contd..

- Home Based HTC
 - ~1.5 million by end June 2011
 - High prevalence, high density rural and urban
 - 80% coverage for adults, high-risk youth and children
 - Special emphasis on couples



Conclusion

- Home-Based HTC is component of the HTC jigsaw puzzle
- Home-Based HTC is prevention
 - Not just about testing
- Home-Based HTC involves specific targetting
- People are willing to be tested at home



Acknowledgements

- **Members of the HTC standing committee**
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