



MSM peer educators
Photo credit: Rose Wilcher

#EAWA

Accelerating progress toward the “First 95” in Togo

September 2019

BACKGROUND

Around the world, countries are working to end the AIDS epidemic by pursuing the 95-95-95 targets set by UNAIDS. The aim of these targets is that by 2030, 95% of all people living with HIV will know their status, 95% of those diagnosed will receive antiretroviral therapy (ART), and 95% of those on treatment will achieve viral suppression.

The West African country of Togo has made some progress toward these targets in recent years, but substantial gaps remain. As of 2018, an estimated 73% of people living with HIV (PLHIV) knew their status, and only 60% of them were on treatment. Moreover, the estimated HIV prevalence of 13% among sex workers and 22% among men who have sex with men (MSM) far exceeds the general population prevalence of 2.3% (UNAIDS, 2019), so focused efforts tailored to the needs of key populations (KPs) are critical.

High levels of stigma and discrimination against PLHIV and KPs, the criminalization of same-sex sexual practices and sex work, and a fragile health system in Togo pose major obstacles to more efficient progress. But, despite the challenging environment, Togo is poised to transform its response to the HIV epidemic. Along with Burkina Faso, Togo is home to the Ending AIDS in West Africa project (#EAWA). Launched in September 2017 and led

by FHI 360, #EAWA is a five-year cooperative agreement funded by the U.S. Agency for International Development (USAID) with the goal of accelerating progress in the region toward the 95-95-95 targets by improving access to prevention, care, and treatment services, particularly among KPs.

In Togo, FHI 360 is working with local partners, Force en Action pour le Mieux etre de le Mere et de l'Enfant (FAMME) and Espoir Vie Togo (EVT), to improve access to and uptake of HIV services among female sex workers (FSWs) and MSM, including prevention, HIV testing, long-term treatment, and viral load testing services. FAMME, a nongovernmental organization (NGO) founded in 1990, serves FSWs, their children, their clients, and other vulnerable women. EVT is an NGO that was created in 1995 to care for PLHIV. More recently, EVT has expanded its programming to include a focus on reaching MSM with HIV prevention, care, and treatment services.



#EAWA

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As the #EAWA project approaches the end of its second year, it is gaining critical momentum toward all three 95 targets. So promising is the progress, in fact, that beginning in October 2019 (FY20), #EAWA will receive additional funds from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) — and be accountable for ambitious new results — with the goal of achieving epidemic control in Togo. As the project prepares for this transition, it is reflecting on and harvesting lessons learned from its implementation experience to date. This brief takes stock of the project's impact on improving the number of PLHIV in Togo who know their status — the first 95 — and how the successful introduction of new case-finding strategies helped it get there.

POLICY CHANGE FOR SUSTAINABLE IMPACT

In 2019, the National AIDS Committee (Comité National de Lutte contre le Sida, CNLS) in Togo reviewed the country's national HIV testing guidelines to determine if any updates were needed in light of emerging evidence-based testing practices and local testing trends. Two members of the #EAWA project team and two representatives from EVT and FAMME participated on the government-led technical working group responsible for reviewing and updating the guidelines.

Recognizing that achieving the targets set for Togo by PEPFAR in FY20 would require introducing new approaches to accelerate HIV testing uptake and case-finding, they successfully advocated with CNLS to endorse three new strategies in the updated

guidelines — the enhanced peer outreach approach (EPOA), index testing, and community-based testing delivered by lay providers. They advocated for index testing (also called partner notification services) and community-based testing because those strategies are recommended by the World Health Organization (WHO, 2015). They also advocated for EPOA given that this case-finding approach, which was developed by the USAID- and PEPFAR-supported LINKAGES project, has been implemented successfully, specifically with KPs in several countries (Lillie et al., 2019).

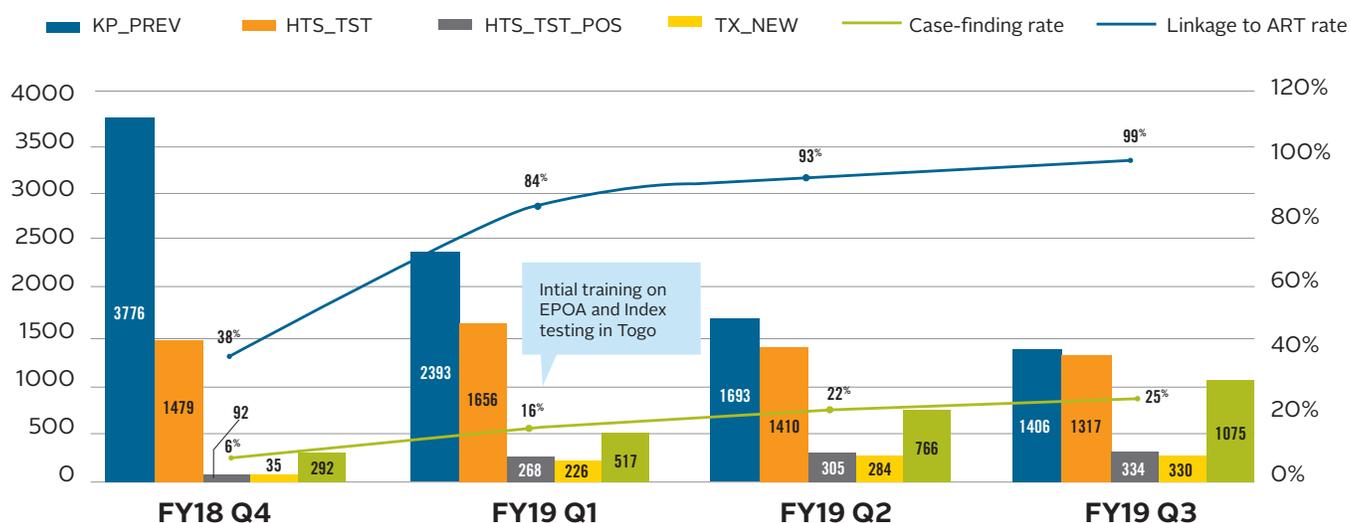
KEY STRATEGIES TO IMPROVE CASE-FINDING

With the introduction of new strategies, #EAWA has observed steady increases in case-finding among MSM, FSWs, and other priority populations, from 6% at the beginning of the project, when it was only supporting traditional peer education outreach and referrals for testing, to 25% just nine months later (Figure 1). These new strategies have also enabled more targeted testing of those at increased risk, such that the number of people being tested is declining but the number being diagnosed is increasing.

ENHANCED PEER OUTREACH APPROACH (EPOA)

EPOA¹ is a peer-led, coupon-based referral network approach used to access hard-to-reach networks of KPs to offer HIV prevention, testing, and treatment services in ways that ensure the privacy of KP members. With EPOA, KP individuals who access HIV testing may be recruited as “primary seeds,” or first-wave

Figure 1. Case-finding rate by quarter for all populations, Togo



¹ For more information on EPOA, please see LINKAGES Enhanced Peer Outreach Approach (EPOA) Implementation Guide.

peer mobilizers (PMs). A good candidate for a seed is someone who has a large social and/or sexual network, is a good communicator, and is willing to be responsible for enrolling peers from his or her network who are interested in taking up HIV testing. Interested peers mobilized by the primary seeds can then be engaged as secondary seed PMs to enroll peers in their networks, thus creating subsequent waves of PMs and KP members reached. This referral system is incentive-based in that PMs are provided with a small incentive for each peer successfully recruited to testing, and travel reimbursements are offered to clients who complete their referral. KP members who test positive are immediately offered and initiated on treatment. Those who test negative are given prevention counseling and commodities (i.e., condoms and lubricants).

In December 2018, #EAWA conducted a three-day training on EPOA with staff from EVT and FAMME. The project then introduced EPOA in Lome from December 15, 2018, to January 15, 2019. EVT and FAMME identified eight PMs and gave each of them five coupons for

recruiting peers to testing. PMs were offered an incentive of 3,000 CFA for each peer recruited, and each peer successfully recruited was offered 2,000 CFA for transportation reimbursement upon arrival at the HIV testing site. Each of the eight primary seeds successfully recruited five peers to testing. All 40 of these KP individuals were then invited to become PMs, 24 of whom accepted. The 24 PMs in this “second wave” were each given three coupons and asked to recruit three peers to testing; however, most only successfully recruited two peers.

Since this initial introduction, #EAWA has been implementing EPOA as a month-long campaign on a quarterly basis. The project has implemented three campaigns to date with promising results. The first EPOA campaign produced case-finding rates of 14.3% and 9.4% for FSWs and MSM, respectively. Those results have steadily increased with each subsequent campaign, most recently reaching 22.4% for FSWs and 20.0% for MSM (Figures 2 and 3).

Figure 2. Case-finding rate from EPOA for FSWs in Togo by quarter

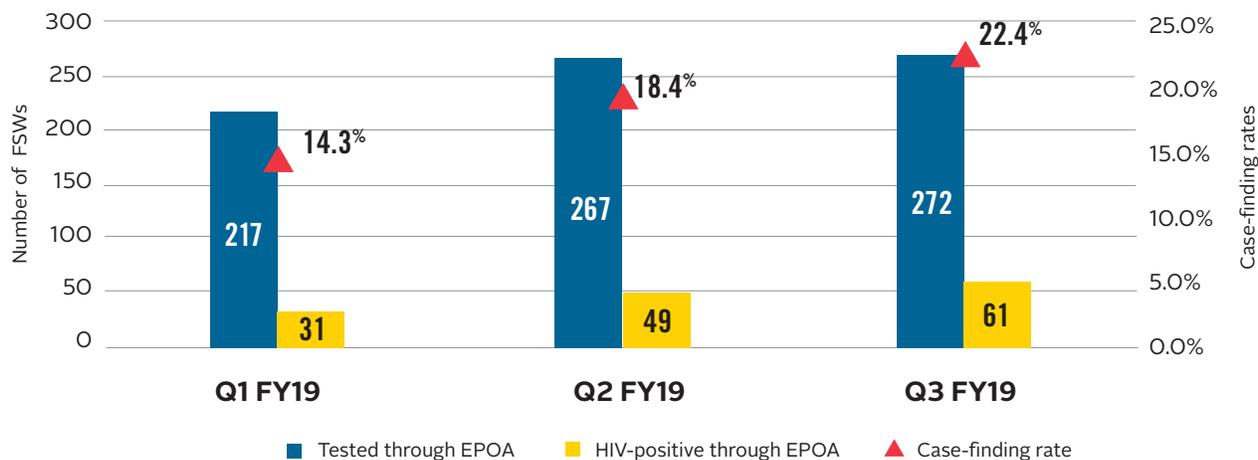
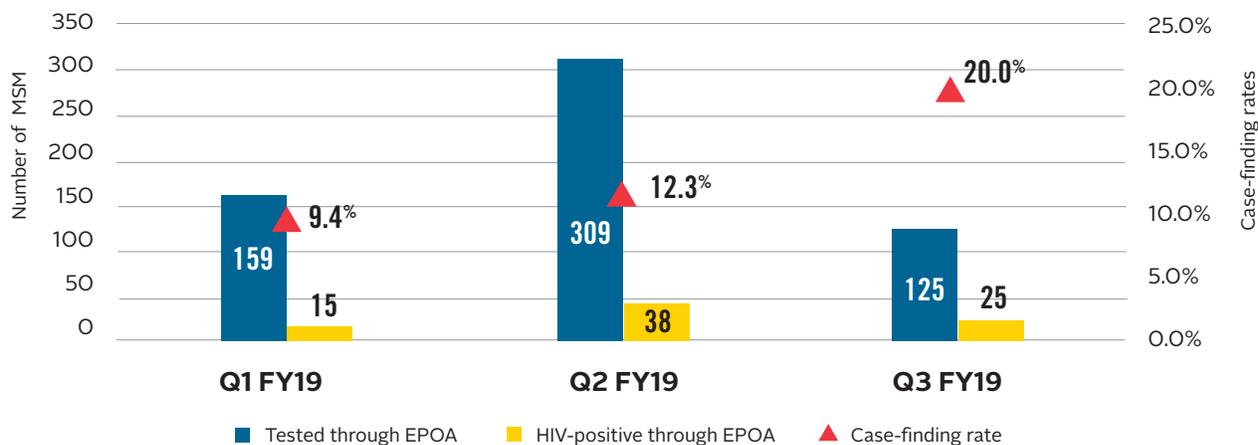


Figure 3. Case-finding rate from EPOA for MSM in Togo by quarter



Early feedback from project beneficiaries suggests that the transportation reimbursement incentive is a big reason EPOA has been so successful. One MSM project beneficiary explained:

- “The first time I heard about EVT was from a friend [peer mobilizer]. He told me there was a project that offered free HIV testing, so I came here for the testing. They told me they would reimburse me for transportation if I came for testing. To be honest, I came for the transportation not for the testing. But I came and got tested and learned that I was positive. At first, I panicked. But then they told me about treatment, and the same day I started treatment. I have been on treatment the whole time...6 months. I never miss my treatment or any appointment.”

In FY20, #EAWA will continue to implement quarterly EPOA campaigns. However, they will use programmatic mapping and size estimation data to ensure they reach new, untapped networks with the campaigns.

INDEX TESTING

Index testing is a focused HIV testing approach in which individuals living with HIV (index clients) are given the voluntary opportunity to list and refer their sexual or drug injecting partners, their biological children, and their biological parents (if a child is the index client) for HIV testing and counseling. Consistent

with WHO guidelines on partner notification, #EAWA's implementing partners offer index testing using both passive and assisted approaches (WHO, 2016). HIV-positive clients are offered various options for contacting their sexual and/or injecting partners, and referral approaches are selected based on the clients' preferences. With the passive approach — also called client referral — the provider encourages index clients to disclose their status to their sexual and/or drug injecting partners by themselves, and to also suggest HIV testing to the partners. The provider does not have any contact with the referrals until the point at which they come in for testing. With assisted approaches, a trained provider is involved in offering HIV testing to the index client's named contacts.

Providers at EVT and FAMME have only been implementing index testing for a couple of months, but the early results are impressive. Compared to EPOA and other testing modalities, such as facility-based provider-initiated counseling, index testing is producing the highest case-finding. For example, in the third quarter of FY19, index testing produced a case-finding rate of 52.1% compared to 25.9% for other facility modalities (without index testing or EPOA performed in the facility), 22% for EPOA, and 16.9% for other community testing modalities (Figure 4).

Figure 4. Case-finding rates by testing modality, all populations, FY19 Q3, Togo

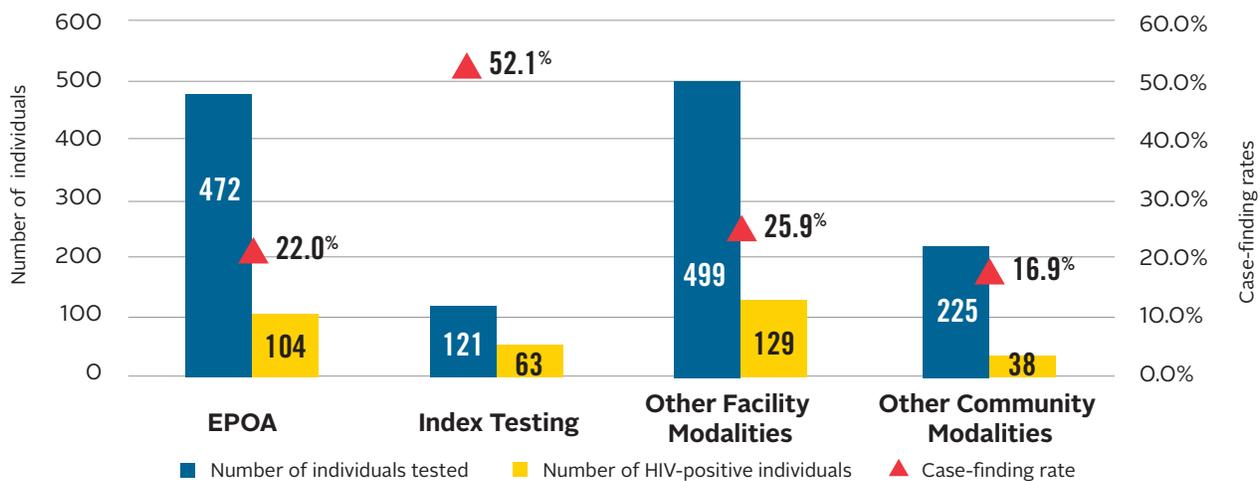
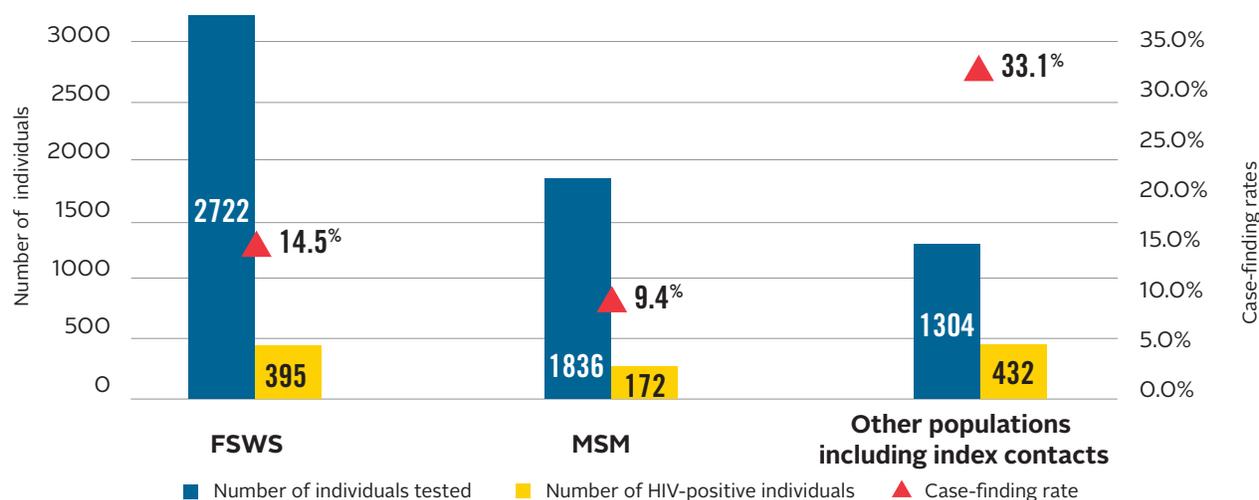


Figure 5. Case-finding by population from FY18 Q4 to FY19 Q3



In addition, index testing is allowing the project to reach other high-risk individuals who do not identify as KP members. Indeed, since the introduction of index testing, case-finding has been highest among members of these “priority populations,” who are referred to testing by FSW and MSM index clients. While overall case-finding during the last year was 14.5% for FSWs and 9.4% for MSM, it was 33.1% for priority populations due to index testing (Figure 5).

#EAWA’s partners acknowledge that index testing is not a new strategy. However, with support from the project, they have been more systematic in their approach to index testing and working to implement it “with fidelity.” One provider noted that, before #EAWA, they were primarily implementing index testing with the family members of PLHIV, and it was not being done consistently with everyone diagnosed. Now, he explained, “it is offered to everyone and it includes a focus on sexual and injecting partners.”

The staff at EVT only started implementing index testing as recommended by #EAWA in March 2019, but they plan to offer it to every one of the 3000+ active PLHIV clients they have at the clinic. Likewise, at FAMME, every person living with HIV who comes for treatment is now offered index testing.

The project staff and partners are encouraged by the early success with index testing in increasing case-

finding. However, they also recognize the importance of proceeding with caution. Because KPs are often stigmatized and fear breaches in confidentiality by health care providers, index testing must always be implemented in a safe, voluntary, informed manner. They noted that the vast majority of MSM and FSW index clients are opting for provider referral — one of the active approaches — because the provider does not disclose who the referral source is. They are able to remain anonymous. One provider explained, “Index testing can be difficult for MSM because it is a very closed community, and no one wants to disclose their status. You have to spend a lot of time talking with them and obtaining consent. Most of them don’t want their partner to know their [HIV] status. It’s up to us to help them feel they can trust us and feel at ease sharing their sexual partner contacts.”

Moreover, staff take care to introduce index testing when they sense that the client is ready for it. As one provider explained, “It’s not systematic to offer index testing on the same day they receive their diagnosis. Some people need time to accept the test results. If people aren’t ready, we wait until they are. We don’t rush.” For index clients who do not want to refer contacts, EVT and FAMME have instead invited them to participate in EPOA. Some have accepted and successfully referred peers in their networks — some of whom may be sexual partners — using the EPOA coupons.

Training MSM peer educators
in community-based testing
Photo credit: Massah Marius

Scaling of index testing will be critical to the future success of #EAWA. The partners in Togo have some solid, early experience from which they will build, guided by the lessons learned so far and aptly summarized by a provider from EVT: “Index testing is not easy; it’s complex. PLHIV are the key to ending AIDS. Index testing can help empower PLHIV to end the epidemic. But, it has to be done right, especially with key populations.”

COMMUNITY-BASED TESTING

When national policy changed in April 2019 to allow lay providers to conduct HIV testing, the #EAWA project immediately moved to train a cadre of peer educators in community-based testing. EVT now has 10 peer educators (9 MSM and one FSW) and FAMME has 10 FSW peer educators who are trained to offer and conduct HIV and sexually transmitted infection testing at hot spots and other community-based venues.

Before conducting testing, the community-based testers conduct a risk assessment with their clients to determine eligibility. Eligible clients are then offered testing. For clients who screen positive, the peer educators refer them to the EVT or FAMME clinic for confirmatory testing. Sometimes the peer educators offer them a referral coupon for the confirmatory testing, but often they accompany them to the clinic. The moment they get a confirmatory positive result, the peer educator offers to link them to a peer navigator or case manager for additional support.

Implementation of community-based testing is supported by microplanning and hot spot mapping. These are strategies to identify precise locations where KP members engage in risky behavior and provide data



necessary to plan prevention and treatment services at appropriate scale and intensity. The peer educators use the data from hot spot mapping and microplanning to determine how many individuals they are responsible for reaching each month and how to locate them.

Already, the #EAWA project staff sense that testing by KP community members holds promise for the project. They noted that a lot of FSWs they were reaching through traditional outreach and referrals for testing were not going to the facility for testing. They believe community-based testing is helping to address this challenge by making testing more convenient for them. Some FSW community-based testers are also finding success by building relationships with the hotel managers where FSWs work. The managers will bring the women together in a group and invite the peer educators to come talk with them and provide testing to those who want it.

They are also finding that community-based testing is helping to expand their reach to KP individuals who are not based in Lome, because the trained peer educators can travel outside of the city — to places where there are no KP-friendly testing facilities — to conduct the testing.



*Training MSM peer educators in community-based testing
Photo credit: Massah Marius*

The peers conducting community-based testing have found it be an empowering experience. With the adoption of this strategy, one MSM peer educator said, “It’s like we are leading the project ourselves now.” An FSW peer educator expressed pride in what she is doing for her community: “You have to build trust with other FSWs before you can convince them to get an HIV test. It can take six months to establish that trust; it may require disclosing your own status. But, we have respect in our communities. We are like ‘aunties.’”

The project just started community-based testing in late April 2019, and it is currently only being implemented at small scale. But, because they are already finding cases with this approach, the team is optimistic that it will be an effective strategy. It will be an important part of the project’s case-finding approach in FY20, with plans to scale it up by training all peer educators to be community-based testers. In addition, they will integrate

it with EPOA and index testing to make testing for network referrals more accessible.

PREPARING FOR THE FUTURE

After two years of project implementation, #EAWA will undergo major changes beginning in Year 3. However, the project staff are ready for the challenges — including an ambitious set of new service delivery targets — that lie ahead. Having seen the potential that these case-finding strategies hold, the project is now well-positioned to scale and optimize them. As a program manager at EVT said, “Back in the day, the peer educators just did outreach and referred for testing, either to a facility or a mobile clinic, and we offered it to everyone and weren’t finding very many cases. But, now we’re doing EPOA, index testing, community-based testing, and we know how to conduct risk assessments for more targeted testing of those at risk. With #EAWA, we have evolved.”

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