

Data Driven Programming: Using Hot Spot Mapping Data to Improve Case Detection and Linkage to HIV Prevention and Treatment Services Among Key Populations in Harare, Zimbabwe.

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Background

- Key Populations (KP) bear a disproportionate burden of HIV in Zimbabwe. Decades of public and private sector work to manage the HIV epidemic has resulted in a drastic reduction of new HIV infections by over 61% between 2010 and 2021. Despite these gains in epidemic control, certain subpopulations including KPs still have high HIV prevalence at 21.1%, 45.1%, 24.1%, 27.5% among men who have sex with men (MSM), sex workers, prisoners, and transgender persons, respectively as compared to 12% among the general adult population in the country.
- Barriers such as stigma, discrimination, criminalization, and socio-economic challenges prevent members of these subpopulations from accessing and continuing HIV services at public health facilities. **Pangaea Zimbabwe AIDS Trust (PZAT) is building the capacity of public health facilities to provide KP friendly services to improve uptake of HIV prevention, care, and treatment services.**
- Hot spots are any physical venues, or places where KPs congregate and these include bars, brothels, hotels, sex dens, houses, casinos, guest houses/rest houses, lodgings among other makeshift spots. Hot spot mapping systematically identifies, assesses, and quantifies KP needs to scale up health and prevention services in the context of HIV, while reducing unnecessary burdens on the health system. Hot spot mapping was implemented to identify locations where KPs can be reached with services that are friendly and responsive to their needs.

Description

From March 2022 to April 2022, PZAT supported the mapping of hot spots in Harare, Zimbabwe. PZAT adapted the FHI360/LINKAGES hot spot profiling and listing tools in implementing the intervention. Community Facilitators (sex workers, MSM, transgender people, and people who inject and use drugs) were trained to implement the activity. Data collection was done through small group dialogue sessions.



Image 1: A KP consultative group drawing preliminary hot spot maps at Kuwadzana Polyclinic in Harare, Zimbabwe

Mapping was carried out in three steps:

Step 1: Preparation

Organization of the tools for data collection, training of dialogue sessions facilitators, identification of dialogue session participants.

Step 2: Data collection

Identification of hot spot areas, profiling of identified spots and conducting validation exercise as part of verification.

Step 3: Data analysis and data use

Data driven programme implementation from key learnings of the hot spot mapping exercise.

Lessons Learned

- A total of 169 hot spots were identified** and supported by peer community cadres.



Image 2: Finalized hot spot map of Warren Park polyclinic area

- There was a substantial increase in the uptake of HIV prevention, care, and treatment services after hot spot mapping as compared to the period before.** The uptake of pre-exposure prophylaxis (PrEP), antiretroviral therapy, and sexually transmitted infection treatment services by KP increased by 92%, 12%, and 127%, respectively.

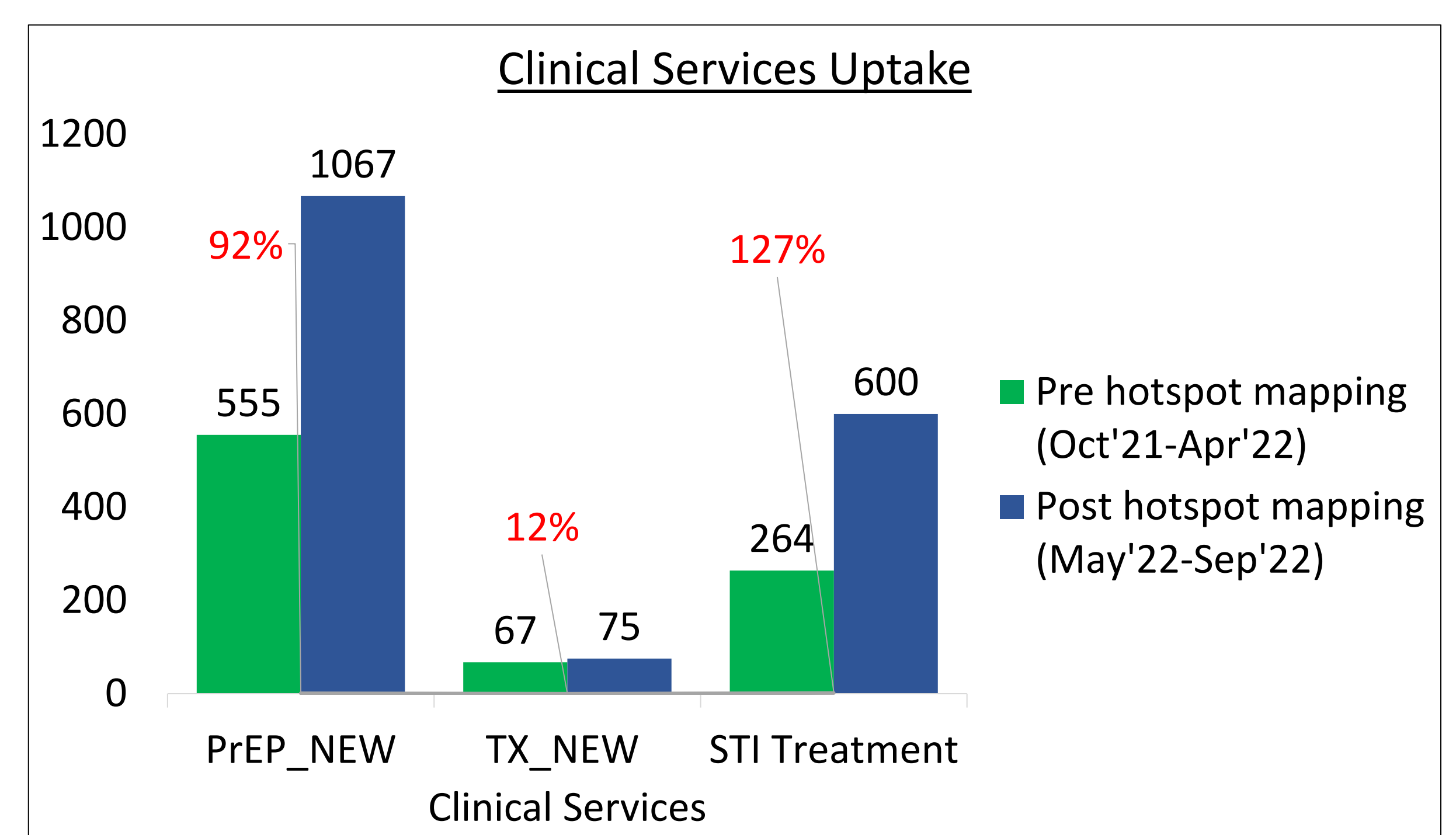


Figure 1: Clinical services provision in Harare, before and after the hotspot mapping exercise

Programmatic changes effected due to hot spot mapping findings:

- To support services and demand creation for the 169 hot spots, **the number of peer-support cadres was increased from 33 to 75.**
- Demand creation activities were scaled up to meet the requirements of the underserved populations. **There was an increase from an average of six outreaches per month to 25 outreaches per month, which improved case detection.**
- The programme supported 18 public sector facilities**, divided into 5 zones with 1 Zonal Community Facilitator per zone supporting 14 peer Community Facilitators activities.
- Preferred times for service uptake, support initiatives and community dialogue favored service uptake day and moonlight. **As a result, moonlight outreaches were scaled up, community dialogues and support groups were increased to improve service delivery** and client follow up support and care.
- Gaps in knowledge were identified and led to an **increase of literacy sessions** for the KP community.

Conclusions

Hot spot areas are places of choice for the KP community as indicated by high numbers reached with interventions following the mapping exercise. Mapping outcomes allowed data-driven programming to improve case finding and provided an excellent basis to implement HIV interventions. Designing HIV interventions for KP that have built-in routine hot spot mapping is a high-impact action.