TRACE Data Interpretation, Use, and Public Health Response
# Previous TRACE Webinars

[https://trace-recency.org/](https://trace-recency.org/)

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<td>9. TRACE Data Interpretation, Use &amp; Recency Response</td>
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About today’s presentations

Our panelists will share how they have successfully implemented recent infection surveillance and how they are using the data to better describe their local epidemics and mount public health responses.
About Our Presenters

KATIE CURRAN
is an epidemiologist on the Clinical Surveillance and Epidemiology Team in CDC’s Division of Global HIV and TB’s Epidemiology and Surveillance Branch. She is a CDC co-lead for the TRACE initiative.

DUMILE SIBANDZE
is the lead Ministry of Health Principal Investigator on the Eswatini HIV Recent Infection Surveillance (EHRIS) Program.

BEATA SANGWAYIRE
is the Acting Director for HIV Prevention Unit within the HIV/AIDS, STIs and OBBI division at the Rwanda Biomedical Center.
Introduction

KATIE CURRAN
CDC co-lead for the TRACE initiative
Webinar Overview

• Background
• Data use for surveillance: Characterizing the epidemic
• Data use for response: Acting on recent HIV cases
• Case Study: Eswatini
• Case Study: Rwanda
• Discussion
Progress Towards 95-95-95

COP20 Guidance; PHIA Surveys.

*Data based on self-reported status, ARV metabolites still being analyzed.
Data Needs in the Era of Epidemic Control

- Fewer new HIV infections
- High ART coverage among all PLHIV

Data Needs to Reach and Sustain Epidemic Control

• **Case surveillance:** To follow individuals across the continuum of HIV care and devise client-centered services to respond to gaps

• **Recent infection surveillance:** To describe where and among whom new HIV infections occur and mount public health response
  
  • Understand factors driving ongoing HIV transmission
  
  • Tailor response in specific regions or among subpopulations
  
  • Intervene in time to prevent onward transmission and improve health

Case-based/Recency Surveillance: Stages of Public Health Surveillance & Response

Planning & Training

Standing up system

Site Implementation

Scale-up

Monitoring and Expansion

Real-time data review

Investigation

Response

Data Use
Data Use: Recent HIV Infection Surveillance

1. Monitoring Quality
- Assess data completion
- Review test performance
- Review testing quality
- Assess plausibility of data
- Previous webinar

2. Surveillance & Response
- Describe where and among whom new infections occur
- Act on recent cases
- Guide public health response and better target resources

3. Monitoring Progress & Program Impact
- Monitor key indicators
- Interpret data in context of epidemic control
- Future webinar

https://trace-recency.org/example-dashboard/ (Simulated data)
1. Monitoring Quality of Data

Review country recency data on dashboard for:

1) Data completeness
2) QC testing for site participation, testing frequency, data completion and results
3) Performance of diagnostic verification line
4) Trends of recent infections and plausibility of results

https://trace-recency.org/webinars/ (August: CQI; December: Lab QC)

https://trace-recency.org/example-dashboard/
2. Using Recency Data for Surveillance: Characterizing the Epidemic
Who is represented in recency surveillance data?
- Persons seeking care receiving HTS, eligible for RTRI, accepting RTRI, and having results
- Among sites offering RTRI & reporting data

PLHIV (People Living with HIV)
Who is represented in recency surveillance data?

Eligible for RTRI, accepting RTRI, and have RTRI result

Newly Diagnosed HIV+

Known HIV+ Status on ART

Known HIV Status not on ART

KEY

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<tr>
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<tbody>
<tr>
<td>🔴</td>
<td>Known HIV positive not in care</td>
</tr>
<tr>
<td>🔵</td>
<td>Known HIV positive on ART virally suppressed</td>
</tr>
<tr>
<td>🔴</td>
<td>Known HIV positive on ART with viremia</td>
</tr>
</tbody>
</table>

How and do we need to consider these two groups in recency surveillance?
Questions

• Describe data
  • Where and among whom are recent HIV infections occurring (# and %)?

• Interpret data
  • What may explain these trends or patterns?
  • What other information would you like to know?
  • What are the limitations of the data?
  • What do we know about the quality of the data?

• Use data
  • How would you use this data to inform the HIV program?
**Contextualize Data:** What other data sources are available to triangulate?

<table>
<thead>
<tr>
<th></th>
<th><strong>Baseline epidemiologic situation:</strong> Prevalence, incidence, disaggregates by geography, age, sex, and KP type</th>
<th>Sources: BBS, KP population size estimates, PHIA or population-based data, programmatic data, and modeling data</th>
</tr>
</thead>
</table>
| 2) Reach | • Number and % of persons reached with testing – who are we missing?  
• Retesting behaviors – for confirmation, because high risk or in risk network, posing as unknown status | Sources: PHIA surveys, program M&E reports (NGOs, MOH, MER indicators), facility data, HIV case reports, and other surveillance data |
| 3) Testing | • Quality of testing: Is the test being done and documented properly?  
• RTRI vs RITA: What percentage were misclassified? What are the reasons? How does that impact the data? | Sources: Lab QC data and VL data |
| 4) Data quality | Triangulate with other sources of data. | Sources: M&E data, facility data, HIV case reports, and other surveillance data |
Interpreting Recent Infection Trends

- Know your population
  - TRACE provides trends in the proportion recent among those with newly diagnosed HIV infection
  - Context and data triangulation are critical for interpretation of trends
    - Program’s HIV testing approaches, including risk screening
    - Persons’ HIV testing patterns
    - Review of epidemiologic data to establish baseline
Interpreting Recent Infection Trends

• Know your implementation
  • Consider your denominator
    • Is recency testing among all persons newly diagnosed with HIV? Or among those enrolling in ART?
    • Are they truly newly diagnosed - what about those who are retesting?
    • Are you seeing a lot of refusals for recency testing, which could introduce bias?
Interpreting Recent Infection Trends

• Know your implementation: RTRI or RITA?
  • Is viral load testing done for RTRI-recents (RITA) to improve positive predictive value of recent infections?

Most females aged 40-44 RTRI Recent had VL<1,000
Interpreting Trends in % Recent Infection

• Proportion new diagnoses testing recent may be affected by:
  • HIV incidence (disease burden & effective interventions)
  • Population tested (likelihood of testing those with new infections)
  • Testing modality & testing frequency (likelihood of diagnosing close to time of infection)
  • Number tested (denominator)
Example: High vs. Low Recency Proportions

• As different populations are tested
  • Proportion with recent infection among those newly diagnosed with HIV could be higher if we are testing a young population (e.g., women at routine ANC visits)
  • Proportion with recent infection could be lower if we are testing an older population, as there may be many more long-term infections
Example: High vs. Low Recency Proportions

• As countries approach epidemic control
  • Proportion with recent infection among those newly diagnosed with HIV could increase over time if we are diagnosing people earlier

• However, the “rate” of recent infection (HIV incidence) in the uninfected tested population could decrease over time if infections are prevented, treated, and virally suppressed
2. Using Recency Data for Response: Acting on Recent HIV Cases
Opportunities to Identify Partners and Prevent Transmission

• An individual with a recent infection had a partner in last 12 months who could be:
  • Partner newly diagnosed, previously unaware; or
  • Partner known positive, but not engaged in care; or
  • Partner known positive, engaged in care, but not virally suppressed; or
  • Partner tested HIV negative

• Elevated viral load + (likely) unaware of status + current behavioral risk = increased risk of onward transmission
Summary

- Recency data is meant to be used and interpreted in real-time
- Ensuring quality should be an ongoing process as part of CQI
- Must understand the population captured in recency surveillance systems—caveats are important
- Each and every new recent infection case should be acted upon with recognized approaches to ensure prompt treatment and prevent transmission to partners
- Appropriate public health response at national, sub-national, and site level based on critical emerging trends
- Epidemic control is within our reach!
Eswatini HIV Recent Infection Surveillance (EHRIS) Program

Dumile Sibandze
EHRIS MOH Principal Investigator

Data Sharing Webinar, 29 January 2020
Outline

• Introduction to EHRIS: Objectives, Methods and Approach

• Cluster detection and Response Activities, Preliminary Findings

• Next steps
Introduction to EHRIS

• Eswatini surveillance for HIV-1 recent infections:
  – Eswatini HIV-1 Recent Infection Surveillance (EHRIS) Program

• Funding and Technical Support by Centers for Disease Control and Prevention (CDC) U.S. President’s Emergency Plan for AIDS Relief (PEPFAR)- Country Epi Cooperative Agreement
  – Support from the global initiative for Tracking with Recency Assays to Control the Epidemic (TRACE)
1. Monitor trends in the proportion testing recent on the RITA among newly diagnosed PLHIV by select demographic and HIV risk variables to inform targeted HIV prevention interventions.

2. Identify key geographic clusters associated with testing recent on the RITA to inform geographic prioritization of HIV prevention interventions.
Methods

• Surveillance program introduced onto routine HTS platform
  – EHRIS information included in pre-test counseling
• Laboratory testing
  – Rapid tests for recent infection (RTRI): Asante
  – Recent infection testing algorithm (RITA): Asante + VL testing
• Asante testing is in parallel with Unigold testing on national HTS algorithm
• VL sample collection in tandem with pre-ART baseline blood collection
• RTRI and VL results for program use only, not for clinical management, not returned to clients
Implementation Milestones

Setting up systems: Protocol development, approvals, start-up

Assembling teams and training

Site implementation: 39 sites + 1 community partner

Cluster detection and response strategy development

Training by TRACE and CDC Teams in NYC
Draft Strategy
Adapt Tools
Refine dashboard
User access

Data Use

Real-time data review

Training of additional sites

Cluster Investigation (Pilot)

Program Response

Response

Full activation of 37 health facilities and 3 community partners

Jan-Jun 2019

Jul-Aug 2019

Sept-Oct 2019

Nov 2019

Dec 2019

Jan 2020
Generic Cluster Detection and Response

Steps

Step 1: Identify and characterize clusters
Step 2: Cluster Confirmation and Prioritization
Step 3: Respond to confirmed and prioritized clusters
Step 4: Document and communicate outcomes of recent infection cluster investigation, close cluster
Step 1: EHRIS Thresholds

1. Facility testing:
   - $\geq 4$ probable recent cases (by RTRI) per site per month
   - $\geq 3$ confirmed recent cases (by RITA) per site per month
   - Top 10 facilities with the highest number of RTRI recent infections

2. By community or area of residence:
   - $\geq 4$ probable recent cases (by RTRI) per inkhundla per month
   - $\geq 3$ confirmed recent cases (by RITA) per inkhundla per month
Step 1: Facility Level

- Top 10 facilities with highest number of RTRI recent infections

<table>
<thead>
<tr>
<th>Region</th>
<th>Inkhundla</th>
<th>Facility</th>
<th>RTRI Recent</th>
<th>Recent %</th>
<th>Long-Term</th>
<th>Long-Term %</th>
<th>Total (Valid RTRI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manzini</td>
<td>1</td>
<td>A</td>
<td>19</td>
<td>40%</td>
<td>28</td>
<td>60%</td>
<td>47</td>
</tr>
<tr>
<td>Lubombo</td>
<td>2</td>
<td>B</td>
<td>9</td>
<td>23%</td>
<td>31</td>
<td>78%</td>
<td>40</td>
</tr>
<tr>
<td>Manzini</td>
<td>3</td>
<td>C</td>
<td>9</td>
<td>15%</td>
<td>53</td>
<td>85%</td>
<td>62</td>
</tr>
<tr>
<td>Hhohho</td>
<td>4</td>
<td>D</td>
<td>8</td>
<td>31%</td>
<td>18</td>
<td>69%</td>
<td>26</td>
</tr>
<tr>
<td>Hhohho</td>
<td>5</td>
<td>E</td>
<td>7</td>
<td>14%</td>
<td>43</td>
<td>86%</td>
<td>50</td>
</tr>
<tr>
<td>Hhohho</td>
<td>6</td>
<td>F</td>
<td>7</td>
<td>11%</td>
<td>57</td>
<td>89%</td>
<td>64</td>
</tr>
</tbody>
</table>
Step 1: Facility Level

- Review of Recent Infection Testing Algorithm (RITA):
  - Review of RTRI and VL results
  - Reclassify some probable recent cases (RTRI) to long-term.
Step 1: Characterization

Characterize recent infections by: age, sex, entry point and location of health facility to understand the context and plan the site investigation.
Step 2: Cluster Confirmation and Prioritization

• EHRIS Team contacted health facility to arrange cluster investigation activities
  – Scheduled date and time
  – Inform health facility management of investigation activities
    • Define visiting team, records review activities, discussions with staff

• Site investigations aimed to:
  – Characterize services offered and populations served at each site
  – Track HIV prevention services offered to all recent cases at each site
  – Understand HIV prevention and treatment services offered
  – Understand site level tracking of index testing

• Piloted cluster detection and response tool
• All responses entered into ODK
Preliminary Findings

Of 45 recent infections from 4 health facilities:

- All initiated ART
- 71% offered partner/contact notification services
  - 88% accepted and provided contacts

Of 52 contacts:

- 60% tested
  - 29% HIV positive – all but 1 initiated ART
  - 71% HIV negative: no records of PrEP or VMMC referral or services
Possible Implications

• Facility-Level:
  – Need for enhanced standard of care for HIV prevention service referral, delivery and documentation
    • PrEP
    • VMMC
  – Improve documentation using consistent unique identifiers to facilitate objective review of linkages to services

• Above site
  – Review of guidelines/SOPs for HIV prevention services
    • Including objective measures of services received
Lessons Learned

• Communication to MOH, facilities and implementing partners necessary to facilitate site access
• Must negotiate facility permissions for data access e.g. electronic data systems (e.g. CMIS)
• Challenges with routinely collected data must be navigated
  – Variability in record keeping systems (paper vs electronic; different versions of electronic systems)
  – Inconsistencies in identifiers to track services received across programs (especially those HIV negative)
  – If it is not written, was it done? Inconsistencies in documenting services received
Next Steps

• Adopt recency response strategy for scale-up
• Feedback to the national program about the findings on HIV prevention services
• EHRIS Protocol updates and re-approval
• Stakeholder engagement on implementing and sustaining the response (Steps 3-4)
  – Targets and milestones
  – Review of the response
  – ‘Closing’ the cluster

– Targets and milestones
– Review of the response
– ‘Closing’ the cluster
Acknowledgements

• Ministry of Health
• ICAP Eswatini & New York
• CDC Eswatini & Atlanta
• EHRIS & TRACE staff
Siyabonga

**Funding:** Strengthening National Epidemiologic and Research Capacity to Improve Health Outcomes in the Kingdom of Swaziland Under the President’s Emergency Plan for AIDS Relief (PEPFAR) Swaziland under cooperative agreement U2GGH001271. Additional support provided through the Tracking with Recency Assays to Control the Epidemic (TRACE) program (NU2GGH002171-01-00)
TRACE Data Interpretation, Use, and Public Health Response

Beata SANGWAYIRE
RWANDA BIOMEDICAL CENTRE

January /2020
Background

- Rwanda is committed to achieving the global target of ending the AIDS epidemic by 2030.
- Integrating HIV recency testing into routine testing was initiated as an innovative approach to efficiently monitor the HIV epidemic (n=568 sites reported from July 2019), *(source: HMIS)*
- Case based surveillance (CBS) and recency testing started in October 2018 (n=23 sites).
- Started ongoing scale up CBS and recency testing as national program.
Rwanda in the Era of Epidemic Control

Total Deaths to HIV Population

1. **Point-of-care testing (POCT) for recency** at 23 CBS sites in Kigali.
   - RTRI recent samples sent to National Reference Laboratory (NRL) for viral load (VL) testing to confirm HIV recent infection.

2. **8 VL testing hubs.**
   - Health facilities send eligible samples for RTRI testing and VL confirmation (as needed) to VL testing hub in catchment area
   - NRL lead QA activities
Integration or Recent Infection Surveillance in Case-Based Surveillance and Index Testing Programs

At the site level package of care

- Recency testing integrated into Case Based Surveillance (CBS)
- Index testing: Newly diagnosed HIV cases using the national algorithm
- Enrollment, Active Linkage to Care and Treatment for index cases within 7 days
- Active Case Finding
  - Family Testing
  - Partners notification services (Continuous)
  - Social network
  - Longitudinal follow-up into case-based surveillance
RITA Recent and RITA Long-Term, by Month
[Oct 2018 – Dec 2019]

Total RITA = 4,293

Month, Year

Number

Oct, 2018  46
Nov, 2018  15
Dec, 2018  13
Jan, 2019   17
Feb, 2019   23
Mar, 2019   23
Apr, 2019  346
May, 2019   22
Jun, 2019   381
Jul, 2019   364
Aug, 2019   420
Sep, 2019   372
Oct, 2019   360
Nov, 2019   371
Dec, 2019   310

1/30/2020
RITA Recent, by Province
[Oct 2018 – Dec 2019]

Total RITA Recent = 304
RITA Recent, by Age and Sex
[Oct 2018 – Dec 2019]

Total RITA Recent = 304
<table>
<thead>
<tr>
<th>Province</th>
<th>Number RTRI Recent</th>
<th>Number Missing VL</th>
<th>Percent (%) Missing VL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kigali City</td>
<td>472</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Southern</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Western Province</td>
<td>ms_2305</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Eastern</td>
<td></td>
<td></td>
<td>98%</td>
</tr>
<tr>
<td>Northern</td>
<td></td>
<td></td>
<td>98%</td>
</tr>
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Using Recency Data for Impact: Rwanda Example

- HIV National Guidelines
  - In-country Data Use and Response Strategy Workshop
  - On-site Investigation (Mugina)
  - NYC TRACE Response Strategy Workshop
  - In-country Data Use Workshop with Recency Focal Persons

Timeline:
- August
- September
- October
- November
- December
- January
Continuous Data Monitoring
By Above-Site Staff (i.e. RBC and ICAP)

All Recent Cases:
• Linkage and rapid ART initiation
• Ensure VLS
• Index case testing
• Management of partners
  • Ensure engagement in care and VLS for HIV+ partners
  • Prevention (e.g. PrEP) for eligible HIV- partners, Condom, VMMC
  • HTS or use of HIVST for partners of unknown status
  • Family testing
• Members of KP groups
  • Social network testing through KP services

STEP 1: Identify and characterize suspected HIV recent infection clusters

STEP 2: Confirm HIV recent infection clusters and gather additional information for response

STEP 3: Respond to confirmed clusters

STEP 4: Document and communicate outcomes of HIV recent infection cluster investigation

Monthly monitoring of site-level response at site(s) that are part of the cluster

Above-Site Cluster Response by RBC Prevention & Recency Team
(for sites with >2 recent infection cases in a month)

Recency Focal Person (RFP) reports response information for each recent case at the site
Tool: HIV Recency Response Form

Individual Response
(to every individual recent infection case)

Monitoring and oversight of response through review of aggregate data collected by RFP

Monitoring and oversight of response through review of aggregate data collected by RFP

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Monitoring and oversight of response through review of aggregate data collected by RFP
Using Recency Data for Impact: Rwanda Example

<table>
<thead>
<tr>
<th>Province/District/Facility</th>
<th>RITA Recent</th>
<th>Long Term</th>
<th>Long Term %</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern</td>
<td>15</td>
<td>57</td>
<td>79%</td>
<td>72</td>
</tr>
<tr>
<td>Kigali City</td>
<td>7</td>
<td>109</td>
<td>94%</td>
<td>116</td>
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<tr>
<td>Eastern</td>
<td>2</td>
<td>76</td>
<td>97%</td>
<td>78</td>
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<tr>
<td>Northern</td>
<td>2</td>
<td>41</td>
<td>95%</td>
<td>43</td>
</tr>
<tr>
<td>Western</td>
<td>1</td>
<td>66</td>
<td>99%</td>
<td>67</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
<td><strong>349</strong></td>
<td><strong>93%</strong></td>
<td><strong>376</strong></td>
</tr>
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Data-driven exercises to identify sites to investigate

RITA % Recent by District

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<thead>
<tr>
<th>Province/District/Facility</th>
<th>RITA Recent</th>
<th>Long Term</th>
<th>Long Term %</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern</td>
<td>15</td>
<td>57</td>
<td>79%</td>
<td>72</td>
</tr>
<tr>
<td>Kamonyi</td>
<td>3</td>
<td>11</td>
<td>70%</td>
<td>14</td>
</tr>
<tr>
<td>Mugina CS</td>
<td>3</td>
<td>3</td>
<td>50%</td>
<td>6</td>
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<tr>
<td>Gihara CS</td>
<td>6</td>
<td>100%</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Karama (Kamonyi) CS</td>
<td>1</td>
<td>100%</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Kayenzi CS</td>
<td>1</td>
<td>100%</td>
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On-Site Investigation: Mugina Health Center

- 3 HIV recent infections were confirmed by RITA at Mugina Health Center in the month of June 2019
- Site visit was carried out in September 2019 to oversee how cases were managed at the site-level
- Information was gathered through chart review and interviews with facility staff on recently infected individuals and their named partners pulling from various routine data sources at the site
- Also gathered general information about the facility and the local population, including known local “hotspots”
- This information gathering visit helped inform a more detailed pilot strategy
On-Site Investigation: Mugina Health Center

- Chart review and interviews with site staff:
  - Confirmed the 3 cases in recency dashboard
  - Examined:
    - Linkage status of the recent case
    - Contacts and HIV and treatment status
Index case 1
Linked to C&T
19y F
Tested 14/6/19

23, M+ on ART
37, M+ on ART
29, M-
33, M-
47, F+ on ART
41, F+ on ART

Index case 2
38y, M
Enrolled and Linked
to C&T

29, M-
33, M-
47, F+ on ART
41, F+ on ART

Index case 3
19y,F
Enrolled and
Linked to C&T

34, M+ on ART
23, M-

- HIV status known positive
- On ART (but known with poor adherence)
- Partners contacted within 30 days
- Case finding ongoing
- Adherence and counselling ongoing
- Linkage to C&T done on the within 3 days (average)

- Partner successfully contacted and tested within 30 days
- HIV status negative
- Follow up continues, retesting in 3 months
- Counselling, education and provision of HIV prevention services ongoing
Program considerations

- Positive on ART contacts:
  - Enhanced adherence counseling
  - Drug Resistant investigation?

- Negative contacts:
  - Testing of negative contacts
  - Family testing

- Strategy development and operational planning for recency response
  - Validation and approval process
Way Forward and Response Strategies

• Cluster has been defined for the case of Rwanda (≥ 2 recent infections/month in a given HF)

• A recency response strategy has been put in place by ICAP team in collaboration with RBC/Prevention teams

• 7 Recency Focal Persons (RFPs) recruited to enhance response strategy

• 3 seconded staff assigned to RBC to strengthen data collection and use of both CBS and Recency data

• At the central level a CBS core team to meet monthly to analyze data and share experiences guiding investigations and response.

• Recency testing has been integrated into Rwanda’s national guidelines to accelerate the testing of every newly diagnosed HIV positive individual.
Way Forward – Above-Site Response

- Dashboard to be approved for use to visualize data, map clusters and inform the investigations
- Plan and conduct site visit to:
  - Verify and validate data reported (registers, electronic reporting tools, logbooks, client files, etc.)
  - Confirm clusters (using cluster definition)
  - Check on-site level intervention according to the national HIV guidelines
  - Document findings and communicate to HIV Division and stakeholders
  - Focus on clinical mentorship targeting sites with high volume, poor data reporting or/and other concerns.
Conclusions

- Recent infections disproportionately occur in:
  - Young people: 15-24; 25-34 years
  - Females 15-24 where risk of new infection is >3 times higher compared to males
- Recency testing can highlight important programmatic gaps in prevention and treatment:
  - Adolescent and young adults
  - Known positives with adherence issues
  - Negatives linked to RITA Recent cases
Thank you
Discussion
Thank you for attending!