

## NUMAT TECHNICAL BRIEFS

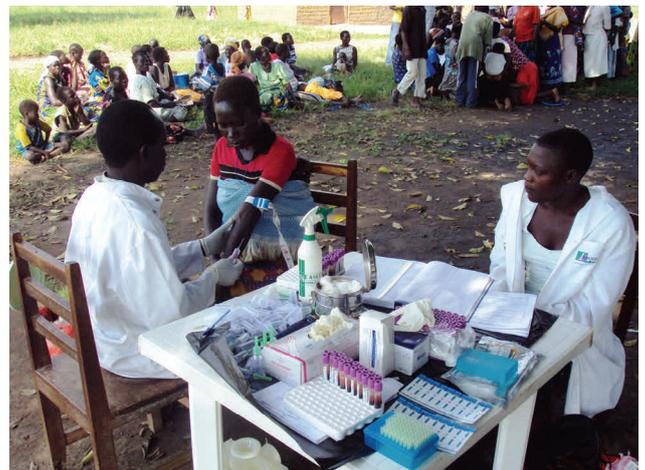
# Expanding Access & Increasing Efficiency of HIV Counseling & Testing through the Provider-Initiated Approach

NORTHERN  
UGANDA  
MALARIA,  
AIDS &  
TUBERCULOSIS  
PROGRAMME  
(NUMAT)

### BACKGROUND & INTRODUCTION

According to the Uganda HIV/AIDS sero-behavioral survey (UHSBS) 2005, HIV prevalence in the North Central Region is 8.2%, a figure that is disproportionately higher than the national figure of 6.4%. In addition, according to the latest assessment by the Uganda Ministry of Health (MOH), less than 40% of the people of reproductive age in the country know their HIV serostatus and even fewer access HIV testing services every year as recommended. This poor coverage is attributed to many factors, including low HIV risk perception and demand for HIV testing, limited availability of testing services and awareness of their location, and missed opportunities to encourage people to test when they visit a health facility.

HIV counseling and testing (HCT) is the process of providing counseling to an individual in order to enable him or her to make an informed choice about being tested for HIV. HCT is a vital component of the response to the HIV epidemic and it represents the entry point for many people to HIV prevention, care, treatment, and support. The benefits of knowing one's status apply to all people, regardless of their HIV serostatus. HCT helps HIV-negative individuals adopt preventive behaviors to remain uninfected and it assists people living with HIV (PLHIV) to access clinical and community-based services to improve their quality of life and survival, and adopt healthy lifestyle choices, including prevention with positives. An important impact of caring for PLHIV is the community benefit, which contributes to reduced HIV transmission and ultimately HIV incidence and prevalence.



**HIV Voluntary Counseling & Testing at a NUMAT-supported outreach.**

In 2009—following recommendations from the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS)—the Uganda national guidelines on HCT were adapted, shifting from the client-initiated voluntary counseling and testing (VCT) to provider-initiated HIV counseling and testing (PITC). PITC is an approach to HIV testing and counseling where the health care provider recommends HCT to a person based on symptoms or signs of illness that could be attributable to HIV, or to all clients visiting a health facility even if they do not have obvious HIV-related symptoms or signs.

The MOH recognized that with the advent of antiretroviral therapy (ART), there was need to increase access to and utilization of HCT and support strong linkages to clinical and social support services. To achieve this goal, innovations were introduced which developed tailored approaches which took into consideration context and approaches for identifying client. Of primary importance was rapidly introducing testing in clinical settings where most PLHIV who do not know their status go for other preventive and curative services. The introduction of routine PITC would offer an additional point of entry to HIV care and treatment for affected individuals and would contribute in expanding knowledge of the HIV situation in the country.

### NUMAT HIV COUNSELING & TESTING STRATEGY

NUMAT worked within existing structures in the public and private-not-for-profit sectors, and the national HCT policy to increase access to and expansion of HCT services in Northern Uganda. The NUMAT strategy complemented efforts of the MOH and other stakeholders within the general framework of the government of Uganda and is described below.

NUMAT consolidated and strengthened existing HCT sites, where services were already provided and also supported the establishment of new HCT service delivery points.

The bulk of HCT services in the region are provided by the existing health facilities, whose activities are also supplemented by outreach services conducted by the NUMAT-supported sub-grantees, namely the AIDS Information Centre (AIC), Medical Teams International (MTI), and Straight Talk Foundation. HCT services had been provided using the VCT approach, and through outreach to communities in hard-to-reach areas and for most-at-risk populations.

NUMAT supported the national HCT guideline shift from VCT to PITC in an effort to replace the system of testing only through VCT departments—that are often over worked and may cause unnecessary barriers to testing, including stigma—and to create more opportunities for individuals to get tested and become aware of their serostatus.

## NUMAT INTERVENTION

The successful roll-out of PITC in NUMAT-supported districts was accomplished by focusing first on selected major hospitals and building the capacity of regional trainers. Working closely with the MOH, NUMAT was the largest partner for expansion of HCT services in Northern Uganda.

Initial roll-out of PITC targeted the six highest volume sites in the region: Gulu Regional Referral Hospital, Lira Regional Referral Hospital, Kitgum Government Hospital, St. Joseph's Hospital also in Kitgum, Apac Government Hospital, and Aber Private-Not-For-Profit Hospital. Regional trainers were created during a training-of-trainers workshop on HCT, implemented by the MOH in September 2009. The resulting regional team of trainers conducted a five-day training at each of the six focus sites in December 2009. These on-site trainings consisted of two days of general instruction for all hospital staff in HIV prevention and referral to HCT services. Afterward, three days were dedicated to educating clinicians and lab personnel on counseling, rapid testing, testing algorithms, supply management, and ordering protocols. This two-phased training enabled the entire hospital to quickly expand HCT services to departments outside of VCT while ensuring that any staff member could direct a patient to testing services most convenient for them.

Technical content covered by the training was determined through a combination of new material dictated by the guidelines as well as results of past assessments. Previous visits to health facilities during routine support supervision determined that there were frequent shortages of test kits—often due to problems in filling out the order forms; therefore this area was emphasized both in training and follow-up mentoring. Also, results from the UNAIDS HIV Modes of Transmission Report for 2009 revealed that 43% of all new HIV infections that occurred among adults in 2008 were among couples. The training was designed with modules specific to counseling and testing of couples, as well as the protocols for filling in couples counseling and testing registers. The use of these past assessments and studies resulted in a training tailored to the needs of the hospitals.

Accompanying didactic methods were practical modules emphasizing testing algorithms and maintaining and compiling testing records. After establishing these protocols, testing at these six high-volume facilities was expanded to all departments rather than limited to the VCT clinic where previously referred patients may be deterred by long waits or stigma. Each department maintains a separate

counseling and testing record which is compiled at the end of each month with the total numbers tested and counseled for the hospital.

At the end of the training a three-person coordination team was chosen in each of the facilities. This typically consisted of the lab technician, a member of the administration, and one other senior health worker. The role of the team was to oversee the implementation of PITC activities in the various service points in the health facility. The laboratory technician was assigned with ensuring availability of HCT supplies in the hospital and distributing the supplies to the various service points as needed.

Quarterly mentoring reinforced and refreshed VCT training in all departments. NUMAT developed supervision guidelines to provide structure to the three-day on-site mentoring performed each quarter, at each hospital, by a minimum of two members of the training team. During mentoring visits, the trainers sit one-on-one with health workers in need of coaching, observe sessions of counseling and testing, and take inventory of test kits.

In addition to regular mentoring, NUMAT staff attended a monthly coordination meeting at each of the six hospitals. At this meeting, each department presented the total number of people tested and counseled from their register, as well as the current inventory of test kits. If there were departments doing very little or too much testing, these discrepancies were discussed. Stock of kits may also be redistributed between departments to ensure complete coverage. Challenges and successes were discussed and feedback was given. For occasions when the hospital as a whole experiences a stockout of test kits, NUMAT provided emergency back-up stock. These monthly coordination meetings, often happening immediately before the monthly mentoring, offered trainers the opportunity to prioritize and target their mentoring to departments that may need more assistance. Additionally, it presented the opportunity to compile reports of monthly outputs and discuss the achievements.

These hospital-based trainings followed by monthly mentoring have succeeded in increasing access to testing in NUMAT districts. Using this model, NUMAT recently expanded PITC services to Dokolo Health Center (HC) IV and Amolatar HC IV in December 2010. Roll-out to more health centers is planned on an ongoing basis.

## RESULTS

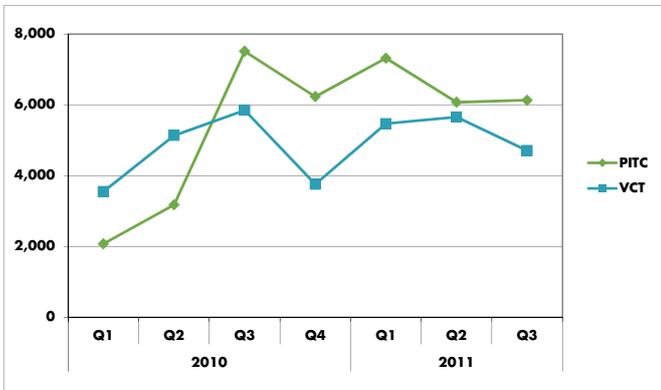
Over 22 months, the introductions of PITC at eight health care facilities resulted in 41,424 patients receiving counseling and testing, in addition to the 35,351 who were tested at the same sites during the same period through client-initiated VCT, representing a 117% in-



**A baby gets tested for HIV at a NUMAT-supported outreach session.**

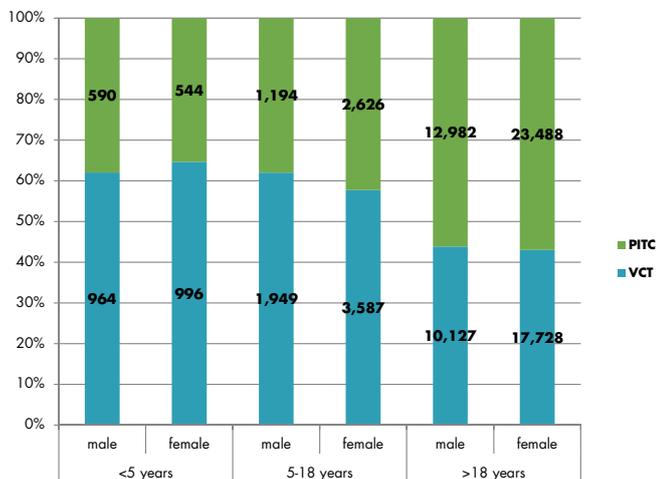
crease of individuals tested. The number of PITC clients increased until reaching a steady number of more than 6,000 per quarter, when all of the eight facilities were fully implementing the strategy (see Figure 1 below).

Figure 1: Trend in client flow over time by testing strategy in 8 health facilities in Northern Uganda, 2010-2011



The majority of clients (64%) were female for both testing approaches, with marked differences especially among adults. Overall, individuals above 18 years of age represented 79% and 88% of clients accessing VCT and PITC, respectively (see Figure 2 below). A higher percentage of the total clients in the over 18 years of age category were tested in the PITC strategy, compared to other age categories.

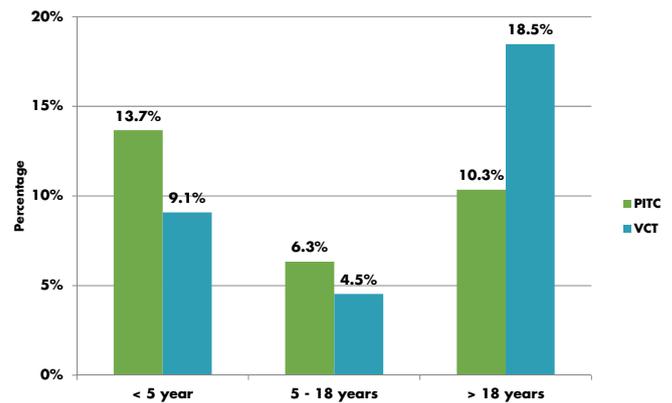
Figure 2: Distribution of HIV testing and counseling clients by service approach, age, and sex in eight health clinics in Northern Uganda, 2010-2011



The aggregated HIV prevalence was found to be higher among VCT clients (16%) than PITC clients (10%) in six of out the eight sites, while PITC clients had higher HIV prevalence in the remaining two; however, there was a noticeable variation among different facilities. The median HIV prevalence in the VCT settings was 12.4% (range: 8.2%-23.4%), while it was 10.2% in PITC settings (range: 6.4%-25.7%). Clearly, there was a wide variation in the percentage of clients testing positive for HIV within these two testing approaches and among the health facilities.

Further examination of the testing data showed that HIV prevalence varied by age (see Figure 3 below). The HIV-positive rate among children under five years of age was significantly higher in the PITC setting than in the VCT setting, 13.7% versus 9.1%, respectively (OR=1.86; p<0.001). Similarly, a statistically significant difference was also found for individuals aged 5-18 years (OR=1.42; p<0.001). Among adults (over 18 years of age), HIV prevalence was higher in the VCT setting than in the PITC, 18.5% versus 10.3%, respectively (OR=1.96; p<0.0001).

Figure 3: HIV prevalence among clients of VCT and PITC by age group in eight health clinics in Northern Uganda, 2010-2011



### LESSONS LEARNED

- VCT clinics remain a focus for HCT in the hospitals, but PITC dramatically increased the numbers tested for HIV and linked to care, as all patients, caretakers, and others visiting the hospitals for any illnesses were identified and given the opportunity to test. In high volume hospitals and HC IVs, using the PITC approach also helped shift the burden of HCT from the lab to the various departments in the facility. This reduced congestion in the lab and improved the quality of service provided.
- More than 95% of health workers in the implementing hospitals are involved in PITC and these are mainly from the outpatient clinics, children’s wards, surgical wards, and antenatal care/maternity. Involvement in PITC has resulted in increased knowledge of HIV information among health workers, as evidenced by the rich content of group talks given to clients in the waiting areas in the facilities.
- The PITC strategy appears to be particularly efficient in detecting HIV-positive children—especially those under the age of five years—compared with client-initiated VCT. A likely explanation is a self-selection bias where an HIV-infected sick child has a higher probability of accessing curative services for HIV-related diseases, thus also receiving an HIV test in PITC-implementing facilities.
- Once established at the facility and internalized by health workers, the PITC strategy can be easily sustained with minimal logistical support including HIV test kits and other laboratory consumable ordered by facilities and provided by MOH.

## CHALLENGES

- Internal support supervision and coordination by the selected teams was affected by frequent staff transfers and attrition. This influenced the motivation of health workers, regularity of supply management, and oversight of service provision in the facilities.
- The PITC model has proven to be a challenge among some health workers who perceive it as an added burden to their already existing workload.
- Retraining is required for some departments that do not commence testing immediately after the training or have had high turnover rates of trained staff. This challenge has been mediated through one-on-one training of key staff during mentoring visits.
- Some facilities still face problems in the proper inventory and timely ordering of HCT kits. The previous non-responsiveness of the National Medical Store has been cited as one reason for this but staff also fill in the forms incorrectly and require continuous coaching in this protocol.



**A health worker examining samples for HIV testing.**

## CONCLUSIONS

HCT service delivery needs to adopt various approaches to be effective and reach the clients who need it. These include client-initiated counseling and testing, which can be facility-based or supplied through an outreach system, and provider-initiated testing and counseling, which is usually facility-based. Being a relatively newer approach, PITC still requires closer interaction with health workers to ensure their continued motivation and support, to provide this vital service to their clients.

In our experience, PITC increased the number of clients tested and detected a higher rate of HIV among youth. For the approach to be entirely successful there is a need to strengthen the logistical component to prevent stockouts of vital supplies, and to develop a standardized mechanism to link HIV-positive clients to treatment, care, and support services.

**NUMAT** is a six-year, USAID-funded project designed to expand access to and utilization of HIV, tuberculosis, and malaria prevention, treatment, and care, and support activities in conflict-affected districts of Northern Uganda.

Over the course of the project, NUMAT has expanded the geographic coverage and populations served through strengthening local government responses, expanding the role of communities in planning implementation and monitoring activities, and building upon existing networks.

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