



Key Steps to Successful Scaling up of Routine HIV Counselling and Testing in Rural Ugandan Clinical Settings: *The Uganda RCT/ BC Project*

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Content outline

- Background
- The RCT approach
- Gaps and interventions
- Key results by March, 2008
- Estimated coverage of eligible patients
- Lessons learnt
- Conclusion

Background

- 85% of Ugandan adults do not know their HIV status (UHSBS 2004/5).
- 70% would like to know
- Uganda MOH HCT policy revised in 2004 to include RCT
- RTI International & AIDS Health Care Foundation (Uganda Cares) piloted RCT in 3 hospitals and 1 Health Centre IV (HC IV) in 2004
- Currently in 8 districts:10 hospitals and 11 HC IVs

The RCT approach

- Provider initiated. Patients' right not to test is respected
- Health talk for all patients
- HIV test offered using the “opt out” approach
- Rapid HIV test for those who do not opt out/ consent.
- Same day results and MOH result slip given
- HIV positive persons get:
 - Counseling on prevention, care, treatment
 - Septrin
 - Referral to HIV clinic for HIV Basic care kits, ART
- HIV negative persons get counseling on risk reduction and re-testing as needed

Gaps and interventions

- Lack of information on capacity to implement RCT
 - Needs assessment conducted
- **Human resource:** Not trained in RCT approach; few in number
 - 1,018 h/ workers trained to counsel, run HIV rapid test and BC
 - Volunteers supported in grossly understaffed units
- **HIV testing points:** Centralized in the laboratory
 - Established additional testing points on OPD and all wards
- **HIV testing logistics:** Frequent stock outs
 - Trained staff in LMIS –accurate and timely requisitioning
 - Support for timely delivery
 - Procurement to cover gaps

Gaps and interventions

- **Quality assurance:** Irregular supervision, quality of performance not known
 - Provided Standard Operating Procedures (SOPs)
 - Conducted monthly technical support supervision
 - Periodic assessments
 - Re-testing of samples in National reference lab - acceptable levels of discordance observed with time

- **HIV care and treatment:** No ART in some H/units
 - Trained staff
 - Accreditation by MOH for ART
 - Support for volunteers
 - Procured septrin to cover gaps

Gaps and interventions

- **Data management:** Available HCT data tools not appropriate for the program
 - Designed simple to use data collection and summary tools
 - Oriented service providers on the tools and process for collecting data
 - Data focal persons to oversee data management
 - Support supervision to ensure quality and timeliness
 - Routinely validated data

Key results by March, 2008

Variable	Result
% of eligible persons who accepted to test	>99%
# of persons counseled, tested and given results	124,964 (28 % were non-patients)
# of HIV positive persons identified	16,157 (13%)
# of HIV positive persons enrolled into care within the same facilities	8,525 (53%)

Estimated coverage of eligible patients

Departments	HC4s	Hospitals	Overall
Outpatients	47%	23%	29%
Inpatients	52%	65%	63%

Lessons learnt

- High acceptance levels for RCT by patients
- Trained and supervised non- lab and non- counselor H/Ws can ably provide RCT
- Frequent staff turn- over necessitates re-training
- Simple to use data tools improve the quality of data
- Decentralizing testing improves access to HCT
- Logistics and data management are critical
- Partnerships improve effectiveness

Conclusion

1. Initial assessment to identify gaps
2. Train all clinical staff
3. Decentralize HIV testing
4. Strengthen testing commodities supply chain system
5. Establish/ adapt data management system
6. Provide SOPs
7. Strengthening linkages to care for HIV + persons
8. Intensive technical support supervision
9. Program monitoring and evaluation

Acknowledgements

- Uganda Ministry of Health
- DELIVER/ Supply Chain Management System
- Strengthening Counsellor Training (SCOT) project
- Mulago-Mbarara Teaching Hospitals Joint AIDS Program
- Population Services International
- Baylor Uganda
- Uganda National reference laboratory
- US Centres for Disease Control and Prevention
- PEPFAR