



Voices on the Ground: Experiences of HBHCT in Uganda

Presented by

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Strengthening HIV Counselor Training in Uganda
(SCOT) Project

The SCOT Project

- Strengthening HIV Counsellor training (SCOT) project, a 5 year, CDC funded collaborative project
- Established in 2004 under the mandate of Ministry of Health and Implemented by TASO (U) Ltd
- To strengthen & standardise HIV counsellor training so as to improve the quality of HIV counselling services in Uganda.



Why the SCOT Project

SCOT was formed to,

- Standardize HIV Counselor training curricula
 - *Review existing counseling curricula*
 - *Develop new ones adapted to complex HIV issues*

- Improve the capacity of Training Institutions to meet the needs of counselors
 - *Training trainers*
 - *Supporting roll-out to increase no. of service providers*



Achievements to-date

- 9 Curricula reviewed and developed through stakeholder consensus.
- 59 Master Trainers trained
- 279 trainers from 104 HIV training and service facilities trained.
- 2, 703 facility service providers and 509 community service providers trained
- 356 HIV service agencies have benefited



HBHCT in Uganda



A typical Uganda home-setting



Rapid HIV testing



Background to HBHCT in Uganda

- Uganda's total population is estimated at 30 million (UBOS, 2000/1)
- 90% of population lives in rural areas (UDHS 2004)
- The HIV prevalence has risen from 6.1% in 2001 to 6.4% by 2005 (MoH – UHSBS, 2004/5)



Why HBHCT in Uganda

Initiated in 2004 due to:

- Need to scale up HIV testing
 - *High unmet demand for VCT in Uganda – about 70% want to know HIV status only 10% have received VCT (USBS 2004/5)*

- Critical opportunity for new prevention, care and treatment programs
 - *ART programs; reducing spread of ARV resistance*
 - *Couples counseling, especially discordant couples*
 - *Prevention with positives*



Why HBHCT in Uganda

- Meet projected global treatment, care, and prevention targets
 - *WHO estimates: meeting projected targets requires testing 175M people world- wide*
 - *A country with a 5% HIV prevalence which targets 100,000 people on ARVs requires to test 10,000,000 by 2008*
- Promote universal access to testing



HBHCT Models/Strategies in Uganda

- Full Access/General Population Approach {ICOB, MUWRP, PREFA, Kalangala & Kumi districts}
 - *House to house*
 - *District-wide coverage*
 - *Involves the general population*
- Targeted/Index client Approach {TASO, MJAP, Baylor College of Medicine}
 - *Targets a program's beneficiaries*
 - *A registered client is the entry point to a home*



HBHCT Strategies - Households

- A household is a unit of measure.
 - *Household refers to selected home of people living together and eating at the same hearth*



HBHCT Strategies – Household members

- Includes couples, individual adults and children (under 18yrs)
- 100% coverage of partners of HIV positive clients
 - Up-take of facility-based partner testing has been low
 - Only 3-12% in most successful programs
- 100% coverage of children under 5 years of HIV positive mothers



HBHCT Strategies – Provider

- HCT provided by trained lay HIV counselor
- HIV Counselor is trained to provide:
 - Pre-test, results and prevention counseling of individual adults, couples and children
 - Finger stick testing with 3 test algorithm
 - Quality assurance using DBS



Successes to-date (1)

- National HCT policy review done - includes HBHCT (2005)
- Development/standardization of HBHCT training curricula, tools and other materials (2005/7)
 - *A trainer's guide*
 - *A participant's Handbook*
 - *Counseling cue cards- Adults, children & testing*
 - *A training video*
 - *Quality assurance tools*



Successes to-date (2)

- Training of National trainers (57) to roll-out training to service providers
- Trained service providers (234)
- About 6 programs have rolled out HBHCT in the Country
- Increased HCT coverage, 12% (2004) to ~37% (2008)
- Increased identification of discordant couples- developed the Couple counseling curriculum



Success factors (1)

- Task-shifting- training lay people to conduct HIV tests
- Mentorship/coaching of trained personnel
- Regular support supervision- QA and QC
- External quality assurance- emphasized for testing
- Availability of Funding



Challenges

At Programming level:

- Costly but highly cost-effective (CDC analysis)
- Scale-up may be difficult without funding
- Increased numbers that require Care vs. inadequate infrastructure/funding
- Linking HIV positives to care
- Testing Children – delay of results, ethical issues



Challenges

- At Implementation level:
 - ICOBI and TASO to bring out these.



HBHCT Curriculum Review



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- Policy bodies: MoH, UAC, & other Line Ministries
- AIDS Service Organizations
- Uganda Counseling Association,
- National Forum for People living with HIV/AIDS Networks in Uganda,



Thank you for
listening

