

ORIGINAL RESEARCH ARTICLE

Assessment of Community Mobilization and Home-based HIV Counselling and Testing Offered by Health Facilities in Rural Uganda

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Abstract

Home-based HIV counselling and testing (HBHCT) and community mobilization have been proven to be effective in increasing the number of people linked to HIV care and treatment. An assessment was conducted in 18 health facilities in Uganda to evaluate the availability and extent of home based testing services and community mobilization activities in underserved communities. The performance of the health facilities was assessed using a checklist with indicators of HBHCT and community mobilization. While most of the health facilities (72.2%) had active community mobilization, only 12.2% had HBHCT services and this might have affected universal access to HIV prevention, care and treatment. The health facilities did not accompany their intensive community mobilization activities with HBHCT yet this provided the ideal entry point and opportunity to improve linkage to HIV treatment and care. *Afr J Reprod Health 2013 (Special Edition); 17[4]: 171-176.*

Keywords: Home based testing, HIV, community mobilization

Résumé

Les conseils et le dépistage du VIH à domicile (CDVD) et la mobilisation de la communauté ont fait leurs preuves pour être efficaces dans l'augmentation du nombre de personnes liées aux soins et au traitement du VIH. Une évaluation a été menée dans 18 établissements de santé en Ouganda pour évaluer la disponibilité et l'étendue des services de dépistage à domicile et des activités de mobilisation communautaire dans les communautés mal desservies. La performance des établissements de santé a été évaluée à l'aide d'une liste d'indicateurs du CDVD et de la mobilisation communautaire. Alors que la plupart des établissements de santé (72,2 %) avaient une mobilisation active de la communauté, seulement 12,2 % avaient des services du CDVD ce qui pourrait affecter l'accès universel à la prévention, aux soins et au traitement du VIH. Les établissements de santé ne sont pas joints à leurs activités de la mobilisation communautaire intensives avec CDVD, pourtant cette condition a fourni le point d'entrée idéal et la possibilité d'améliorer l'articulation au traitement et aux soins du VIH. *Afr J Reprod Health 2013 (Special Edition); 17[4]: 171-176.*

Mots-clés: analyse à domicile, VIH, mobilisation communautaire

Introduction

In order to increase universal access to HIV services, voluntary HIV counselling and testing has been scaled up in most limited resource settings although uptake remains low¹. The low uptake has in part been attributed to the low acceptability of facility-based testing¹⁻⁵. Consequently, home based HIV testing and counselling (HBHCT) has also been seen as a

complementary approach to improving the number of people who know their HIV status and can therefore access HIV services when compared to facility based testing through the removal of logistical barriers^{2,3,6-11}. Almost three quarters of the total population in Africa do not know their HIV status¹². A survey done in 18 high HIV-prevalence countries including 15 sub-Saharan African countries revealed that only 34% of women and 17% of men had ever been tested for

HIV¹³. Knowledge of one's HIV status helps to reduce HIV transmission and improve access to care and treatment¹⁴.

HBHCT allows individuals to learn about their HIV status in their home environment with increased convenience and privacy^{11,15}. There are various HBHCT approaches and these include going door to door in a given area and testing individuals who consent in every household¹⁶. Another strategy is to offer testing services to the family of an existing client in the facility commonly referred to as an index client. Lastly, home based testing may be integrated with other educational and screening interventions such as bed-net distribution¹⁵. HBHCT is seen as an opportunity to reach men and children who rarely visit the health facilities but this can only be successful if there is active mobilization of the communities¹¹. Strong community mobilization efforts help to leverage support for the program by engaging community leaders and household members thus improving acceptability and uptake of HTC services^{11,15}. Community mobilization has played an important role in increasing uptake of HBHCT in many countries and has also been reported to be an effective way in changing attitudes and behavior within communities¹⁷. Countries like Uganda have registered successful implementation of community prevention programmes due to community involvement and participation where different community support groups such as PLWHIV are utilised in mobilizing communities¹⁸. Community mobilization initiatives can be successful if they use already existing resources. For instance, for HBHCT, this includes knowledge, skills and information that can make the most of communities to provide a more relevant and effective response to testing. Ensuring referrals and linkages is important for any HIV service provider if gains are to be made in reducing the spread of HIV. An assessment was therefore conducted to evaluate HBHCT services in 18 health facilities.

Methods

The assessment was conducted in 18 rural health facilities in under-served communities in the Northern, Southern, Central, Eastern and Western

regions of Uganda. The hospitals were supported by AIDS Relief Uganda program offering HIV care and treatment services to more than 80000 people. While the health facilities were at liberty to decide on the implementation of HBHCT, the program supported community support activities such as community outreach HIV testing and home visiting for adherence to ART. The program began in March 2004, working with faith-based and not-for-profit health facilities to strengthen their programming and technical capacities and applying evidence based data to improve care, treatment and community follow up. The assessment was done to measure performance and reveal areas for capacity building thus guiding the implementing partners and donors' decisions on areas that they can invest resources for the development and implementation of strategies. The checklist was developed by the University of Maryland, as part of an annual site capacity assessment (SCA) tool covering the period January 2010 to February 2011. The SCA tool was used for routine program monitoring and supporting the long term sustainability of its local partner health facilities. The results of the assessment enabled AIDS Relief and the local partners to prioritize activities to strengthen capacity where needed. The tool described which health facilities were meeting the minimum standards required to provide quality HIV care and treatment services on a continuing basis. The SCA tool was organized by 12 program components and 7 crosscutting functional areas. Each component included a set of indicators that represented the capacities critical for meeting the standards for quality services. Each indicator had sets of observable statements on a 5-point scale. Level 1 represented not meeting minimum standards, whereas level 3 on the scale represented the pass level for meeting the minimum standard required for quality services. Level 5 represented exceeding minimum standards and a potential best practice. For the continuity of care specific indicators, the scale and descriptors for assessment are shown in Table 1.0. All 18 AR health facilities were included in assessment of continuity of care. An interviewer administered SCA tool was used to assess continuity of care at the health facilities. Data were summarized on excel sheet and

descriptive measures and performance of HBHCT and community mobilization by the health facilities were determined. This assessment sought

to establish if the health facilities provided home based testing as part of increasing the linkages to care through community mobilization

Results

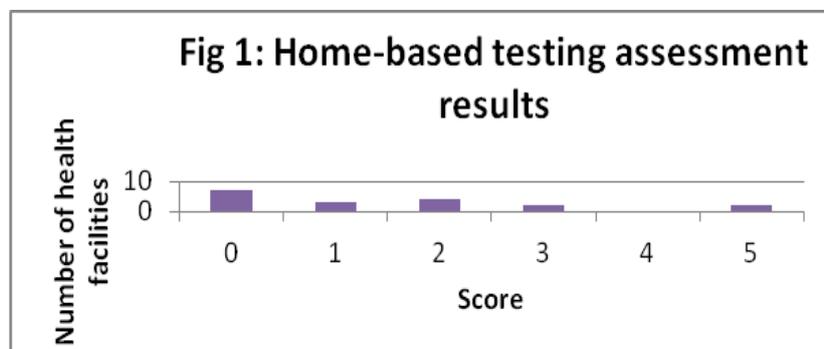
HBHCT

Table 1.0: Continuity of care assessment scale and descriptors

Score	0	1	2	3	4	5
HBHCT Descriptors	No home based testing	Referrals to testing sites provided during community mobilization activities.	Referrals to testing sites provided during home visits and support groups in the community	Home based testing with referral to primary health facility for confirmatory test.	Home based testing with linkage to community programs.	Home based testing linked with community based programs to provide testing and linkage to care
Community mobilization Descriptors	No community mobilization & sensitization efforts	Community mobilization and sensitization provided by other organization.	Community mobilization and sensitization provided through linkage with another organization.	Community mobilization and sensitization provided by volunteers only during campaign efforts	Community mobilization and sensitization provided by volunteers on a routine basis.	Comprehensive community mobilization & sensitization efforts

Most health facilities (77.8%) did not have HBHCT programs (Score 0, 1 and 2) although some of them provided referrals for clients to access testing facilities through the community mobilization activities. Two health facilities (11.1%) provided home based testing with referral to primary health facility for confirmatory test. Only two (11.1%) of the 18 health facilities had linked HBHCT with community based programs to provide testing and linkage to care. The counselling procedure entailed reviewing the HIV facts and benefits of HIV testing in a home setting.

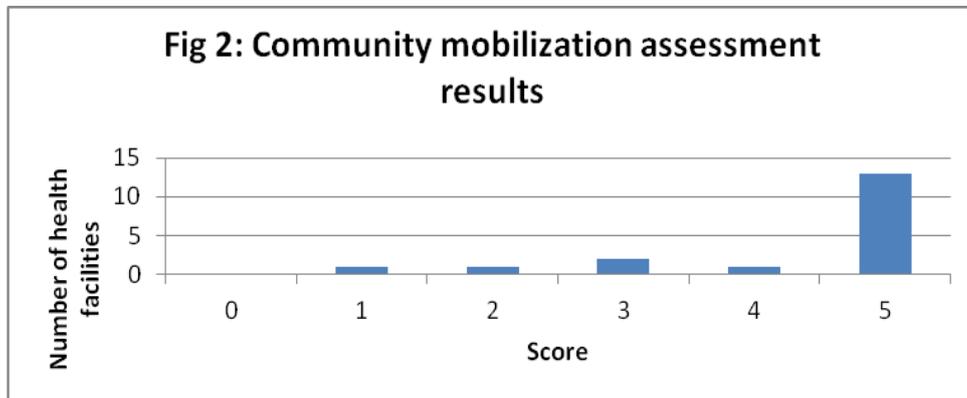
This would be followed with the description of the testing procedure to the family. Pre-test counseling for couples, individuals, and children was done followed by HIV testing for consenting adults and assenting minors. Upon the release of results by mobile laboratory staff, post-test counseling would be conducted. The implications of the results were explained having confirmed client readiness to receive the results. Clients were then assisted to make risk reduction plans and linkage to care and support for those who turned HIV positive was provided. Fig 1 shows the results.



Community mobilization

Majority of the health facilities (72.2%) achieved the highest score for community mobilization and were found to have comprehensive community mobilization and sensitization efforts (Fig 2). Comprehensive community mobilization and sensitization efforts meant that the implementing hospital first secured buy-in from various stakeholders for HIV program implementation. Some of these key stakeholders included district leaders, local council leaders and religious leaders. Secondly, the existing village health teams and PLWHIV groups were identified and formed in organised groups to participate in the mobilisation. These groups were then engaged directly in

mobilisation through door to door method, community meetings and through informal group education, this was always done with the support of the technical hospital staff. Outreach strategies and events were also organised to increase community participation. Activities such as HIV prevention educative drama shows and community sporting events were always organised and these attracted community members and those willing to get tested for HIV were provided with the services. Lastly, the comprehensive mobilisation and sensitization also included live- phone in weekly talk shows and distribution of IEC materials such as T-Shirts, caps, leaflets translated in local language and print media.



Barriers to HBHCT

The health facilities were asked to give some of their reasons for lack of HBHCT services. These included limited availability of HAART slots for eligible clients causing reluctance to intensify HIV testing and counselling. In addition, human resource constraints affected HBHCT in that testing at the health facilities was only performed by laboratory staff that was spread thin and the facilities could not afford more staff to regularly carry out HIV testing in the community.

Discussion

Our assessment found that only a few 22.2% of the sites offered home based testing services to their catchment population of which only half of these linked the home based testing with community

based programs to provide testing and linkage to care. This is very low as a study in Uganda demonstrated that HBHCT increased the uptake of HCT from 18% to 62% in Bushenyi district in 2 years. This was way above the national coverage of 25% and led to reduced stigma and discrimination¹⁹. In order for the health facilities in this assessment to achieve high uptake of HCT and enrol more people into HIV care, they needed to scale up efforts to roll-out HBHCT.

A study in Malawi found that there was high acceptance of HBHCT home based testing²⁰. However, there was a lot of expected stigma associated with HBHCT although this did not result in reluctance in accepting home based testing²⁰. Therefore, HBHCT should be coupled with campaigns against stigma and discrimination and improved confidentiality¹⁶. In the implementation of HBHCT, the creation of an

accepting environment that is supportive to the already affected individuals would motivate other people to access testing services with the hope that they could benefit from the already existing support services¹⁸. In addition, clients should be presented with both options for facility or home based testing so that they can make a choice on the model that suits them best. A cross-sectional survey conducted in Uganda revealed a high acceptance of HBHCT in an urban setting in Rubaga division in Kampala²¹. Maheswaran et al, had similar findings in South Africa⁵. These studies show that HBHCT acceptability in general may be high and health care facilities would benefit by exploring this avenue.

While most studies have focused on assessing barriers to testing from the client perspective^{2,3,6-10}, it is important to also find out the barriers that facilities face in extending home based testing services to their target populations. This assessment established the barriers facilities face in implementing HBHCT and these were related to lack of resources rather than HBHCT acceptability. The main reasons cited were human resource and financial constraints. Similarly, other authors have presented that the shortage of health workers may be an impediment to the implementation of HBHCT in low- income settings although this could be overcome by exploring cost-effective task-shifting models and promoting integration with other programs²¹. This suggested the need to come up with innovative ways of reaching the communities for example, by training community health workers (CHWs) to carry out HBHCT while confirmatory tests would be done at the facility.

Financial constraints impacted on the ability to plan the logistics to conduct HBHCT activities including transport and human resources. It was evident that the health facilities were discouraged from carrying out community mobilization for HBHCT when they could not give care and HAART to all eligible clients that tested HIV positive. The implication here is that whilst access to HAART has increased, more needs to be done to ensure that all those who are need of HAART can access it. In this assessment we found a high level of community mobilization which shows that the facilities have been engaging with their

communities and can provide a suitable platform for successful HBHCT. Most HBHCT programs in Kenya showed high quality community mobilization in their program design and implementation¹⁵. In a study done in Uganda, the number of tested people increased fourfold because of the modified approach of home based testing, a strategy that used community members for sensitization²². Therefore, the success of HBHCT greatly depends on the mobilization of communities when the community members themselves are utilised in such activities. However, one of the main challenges is that a number of community based and non-governmental organisations for people living with HIV, which were traditionally involved in community mobilization and prevention, have shifted their focus to treatment support activities thus jeopardizing the uptake of HCT that had started gaining momentum²³. It is important to also combine HBHCT with “*prevention with positives*” interventions as part of maintaining continuity of care¹⁹. This will help to reduce HIV incidence than solely focusing on prevention with HIV-negative individuals.

Conclusion

It is necessary for health programs and facilities to invest in HBHCT services in order to improve on linking the communities to HIV treatment and care as well as increase the number of people who get tested and know their HIV status for behaviour change. Evidently, more investments are needed to improve access to HAART so that those who need treatment after HBHCT can access it. This will lead to better HIV diagnosis and treatment outcomes. The HBHCT services should be accompanied by intensive community mobilization activities to raise awareness on HIV prevention and treatment in order to preserve and advance the gains made so far in reducing HIV morbidity and mortality. In addition, there is need to recognize that communities are socially constructed within a complex reality and are influenced by diverse stakeholders and values so any initiatives must consider the community context. HBHCT is a key entry point to HIV prevention and communities and households play

a primary role in the HIV/AIDS intervention therefore this community centred approach should be upheld and prioritized.

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Contribution of Authors

CS and AL coordinated the study and drafted the manuscript, PM designed the study and drafted the manuscript, RA helped in drafting the manuscript, and critically reviewed the manuscript. All authors read and approved the final manuscript.

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