Operations Research Brief: What difference does provider-initiated testing and counseling make?

Ethiopia HIV/AIDS Care and Support Project
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OPERATIONS RESEARCH BRIEF

What difference does provider-initiated testing and counseling make?

This brief summarizes the findings of a review of provider-initiated testing and counseling (PITC) and voluntary counseling and testing (VCT) data reported by the 550 USAID HIV/AIDS Care and Support Program (HCSP)-supported public health centers in Ethiopia in 2009/10. The objective of the review was to determine the relative contributions of PITC and VCT to HIV testing and case detection at health centers in Addis Ababa and the Amhara, Oromia, SNNP, and Tigray regions and compare this with outreach testing and counseling.

Background

Following the World Health Organization guidelines, Ethiopia adopted PITC at all health facilities to maximize the number of people tested for HIV, extend HIV case detection well beyond those who actively seek VCT services, and thereby increase the number of HIV-positive people accessing care and support services.

Key Findings

- The number of people tested for HIV at HCSP supported health centers dramatically increased from nearly 1 million in 2008 to almost 3.5 million in 2010. Furthermore, the number of people tested per health center rose from 2,347 to 6,286.

- In 2009/10, the majority (78%) of HIV testing was conducted at 350 HCSP-supported health centers providing antiretroviral therapy (ART). Likewise, these ART health centers identified almost all (90%) new HIV-positive clients. These health centers are mostly those located in urban and peri-urban where HIV prevalence is known to be higher than in rural areas. ART health centers also use a family matrix to identify partners and family members of enrolled patients and encourage them to go to the VCT clinic.

- VCT clinics detected 32,627 (49%) HIV-positive clients at the ART health centers, and PITC identified 34,338 (51%), a similar proportion.

- HIV rates were highest in the tuberculosis (TB) clinics (16.2%), followed by labor and delivery (L&D) wards (4%). HIV positivity rates for all other clinics ranged from 1.5 percent to 2 percent.

- Almost all clients at L&D, antenatal care (ANC), and TB clinics were counseled and offered an HIV test (100%, 91%, and 96%, respectively), and among them, almost all accepted (100%, 96%, and 89%, respectively). Among all clients with unknown HIV status seen at these PITC clinics, the proportions accepting were only slightly lower (100%, 86.8%, and 85.3%, respectively).

- At the other PITC clinics, the proportion offered (20%) and accepting to be tested (74%) was significantly lower (p value <0.00) than at the L&D, ANC, and TB clinics.

- The number of newly identified HIV-positive patients who were enrolled on care and support was 55,657 in 2009/10. This is 83 percent of the number of HIV-positive clients identified by PITC or VCT in 2009/10.

- HCSP-supported community outreach for HIV testing and counseling by 80 health centers in 2008/9 reached 107,706 people but identified new HIV cases in only 0.6 percent of those tested.

Implications

- In contrast to outreach for HIV counseling and testing, which proved expensive and able to yield only a very low number of new HIV cases, PITC and VCT at health centers were highly effective ways to both test many people and detect high numbers of new HIV cases. The data also suggest that PITC and VCT services at health centers effectively linked new HIV cases to care and support services.

- Adding PITC to VCT doubled the number of both people tested and new cases detected; all good HIV programs should, therefore, ensure that both PITC and VCT services are integrated as routine practices at health centers.

- While providers' capacity to offer PITC should be maintained at ANC, TB, and L&D clinics, it needs significant strengthening at the OPDs and FP, EPI, and under 5 clinics, where the number of clients who are offered and who accept to be tested falls far behind the numbers at ANC, TB and L&D clinics.

- One possible way to increase testing at these clinics may be to modify the current PITC approach to shorten the counseling time needed with each patient, especially at the high-patient-load health centers. For example, group counseling in the waiting room and the creation of testing corners so that many clients can be counseled at the same time would reduce the time needed to complete PITC.

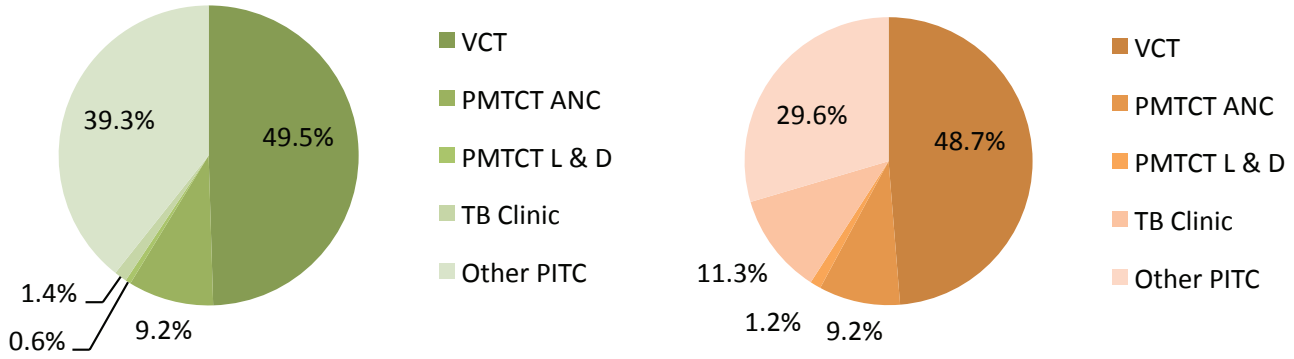

Figure 1: *Percentage distribution of HIV tests conducted (left) and HIV cases detected (right), by clinic, at the 550 HCSP-supported clinics in 2010*

This synopsis is based on research conducted by HCSP team members Tesfaye Arega, Bud Crandall, and Elke Konings.

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