

Background

HIV Testing Services (HTS) programs are operating within increasingly complex environments with more limited resources. National HTS programs are considering how to effectively manage declining testing yields as more people living with HIV (PLHIV) are on treatment, plateauing donor resources dedicated to testing, disparities in testing coverage among different population groups and challenges with linkage, retention and re-engagement in care. HIV Self Testing (HIVST) is one of the innovative HTS approaches has been recommended for integration into testing programs to generate efficiencies. In Uganda, HIVST has been prioritized for secondary distribution at Antenatal Care and direct distribution in community testing. The Ministry of Health (MOH) identified key evidence gaps and opportunities where HIVST could be leveraged to strengthen case finding efforts.

Methods

MOH conducted an implementation pilot between September and December 2022. Primary HIVST distribution was implemented at Outpatient department (OPD) and postnatal care (PNC) across 16 public health facilities using both oral- (Oraquick) and blood-based (Sure Check) kits. Activities conducted included developing training materials, data tools, training service providers and conducting periodic mentorships and supportive supervisions. The basic implementation model included group health talk and demonstration, private space for individuals to test onsite and interpret results, and support with linking to post-test services. Confirmatory testing was offered to clients reporting a positive HIVST and kits were offered to take to home to their partners. Comparative analysis was done for service uptake in conventional HTS versus HIVST, and oral-based versus blood-based HIVST.

Results

A total of 2,411 kits were distributed, representing 52% of the total tests (4,675) conducted between conventional HTS and HIVST. Observed increase in access to HTS for men from 41% (conventional HTS) to 43% (HIVST). Despite slightly lower positivity rate for HIVST (3%) as compared to conventional HTS (5%), there was higher ART initiation rates for HIVST (90%) compared to conventional HTS (85%). Similar uptake of oral- (51%) and blood-based (52%) HIVST across gender and age. Similarly high (90%) ART initiation rates for both oral- and blood-based HIVST.

Conclusion

Integration of both oral-based and blood-based HIVST implementation at OPD and PNC is feasible. HIVST distribution leads to increase in ART initiation which is high program priority. Additional analysis indicates efficiencies on the Human Resources for Health by freeing up health care worker time to other priority activities. MOH should prioritize scale up of facility based primary HIVST distribution.