

# Adherence to EID Testing Algorithm Uganda Experience

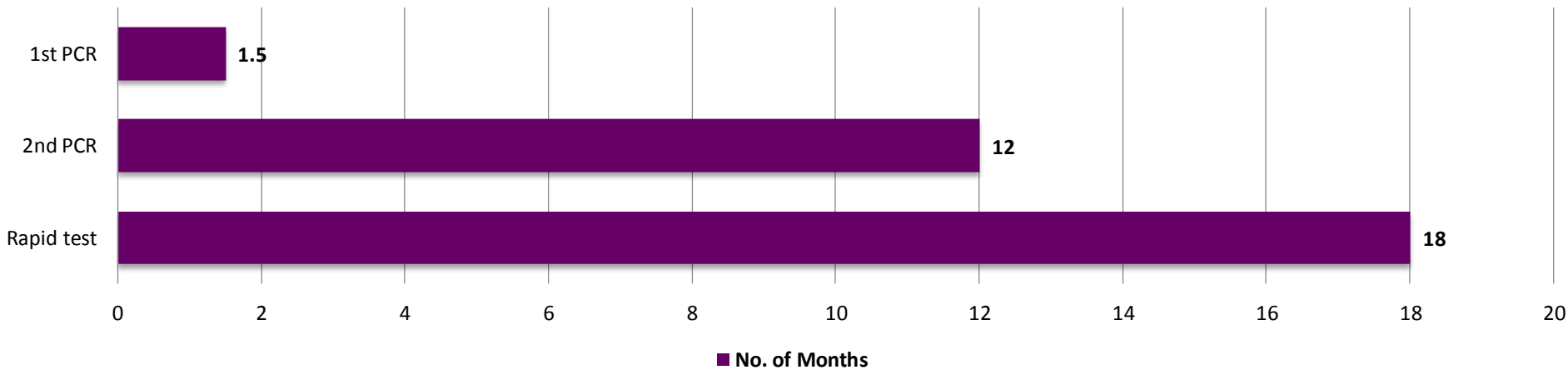
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# EID Testing Algorithm

EID Testing Schedule



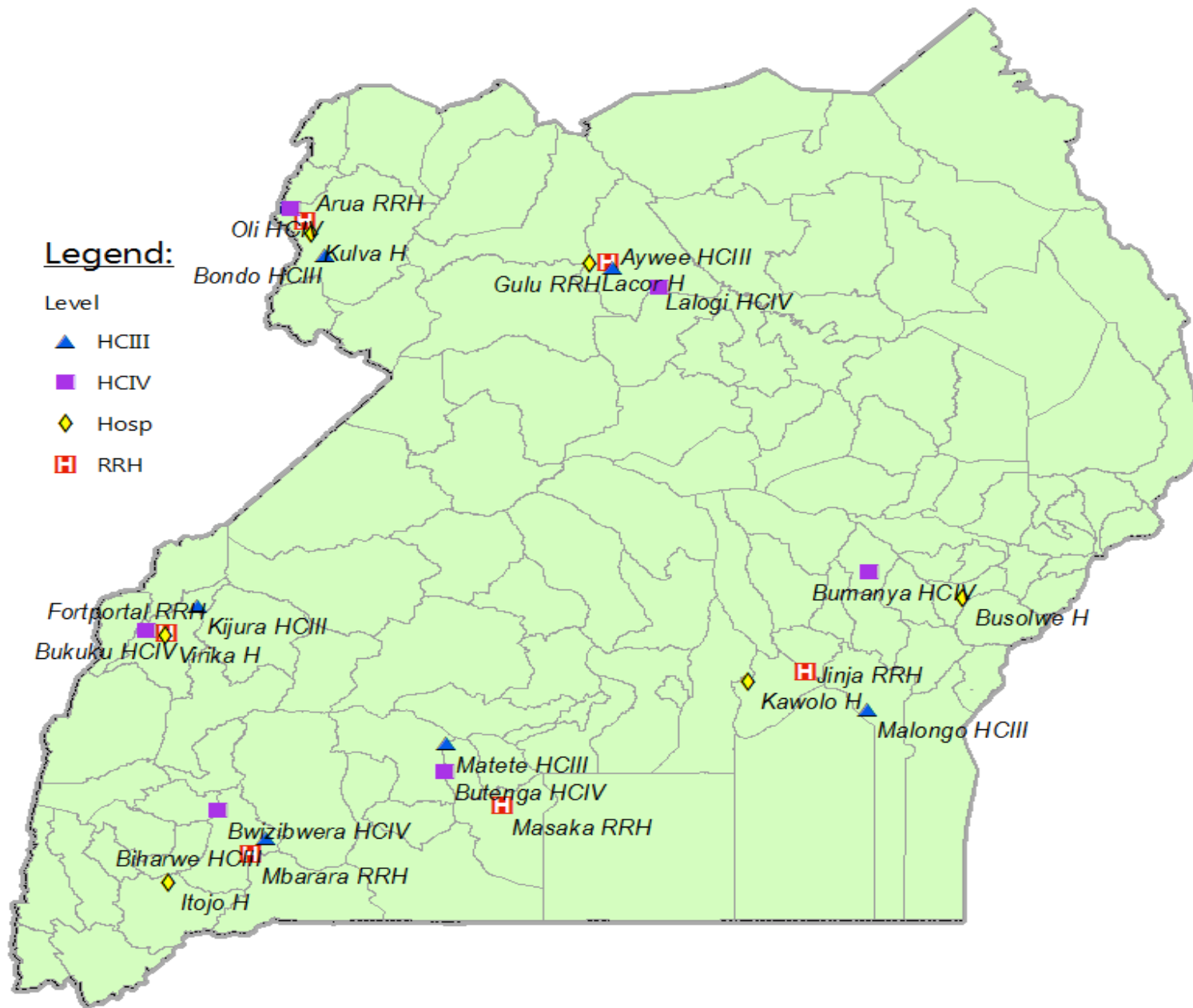
- 1<sup>st</sup> PCR is done at 6wks or any earliest opportunity there after
- Those negative at 1<sup>st</sup> PCR should do a 2<sup>nd</sup> PCR after 6 weeks after cessation of breastfeeding (ideally at 12months)
- All positive infants should initiate ART on the very day they receive results
- All exposed infants who have had a 1<sup>st</sup> PCR test are required do Anti-HIV RDT at 18 months, irrespective of the PCR results

# Adherence to Testing Algorithm Study Sites

- In order to understand the level of adherence to the testing algorithm and retention, we collected retrospective data for 2012 at 24 health facilities, that comprise the full tier of the health system.
- Below are facilities that were visited

<b>Facility Level</b>	<b>No of sites</b>	<b>Total PCR</b>	<b>No HIV Pos</b>	<b>Percentage</b>
RRH	6	2471	209	8.5
GH	6	922	64	6.9
HCIV	6	459	29	6.3
HCIII	6	369	31	8.4
Total	24	4221	333	7.5

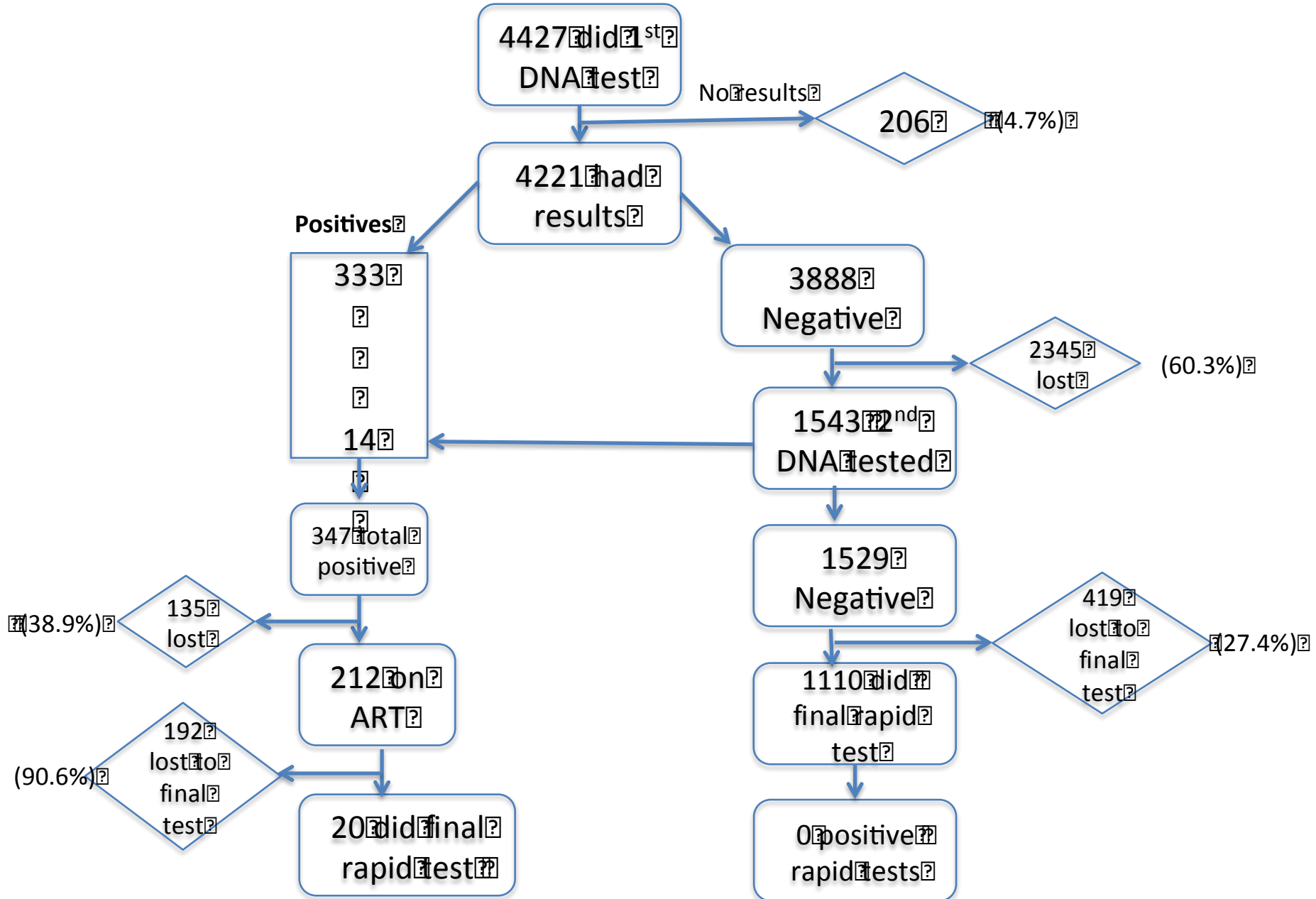
# Adherence to EID Testing Algorithm study sites



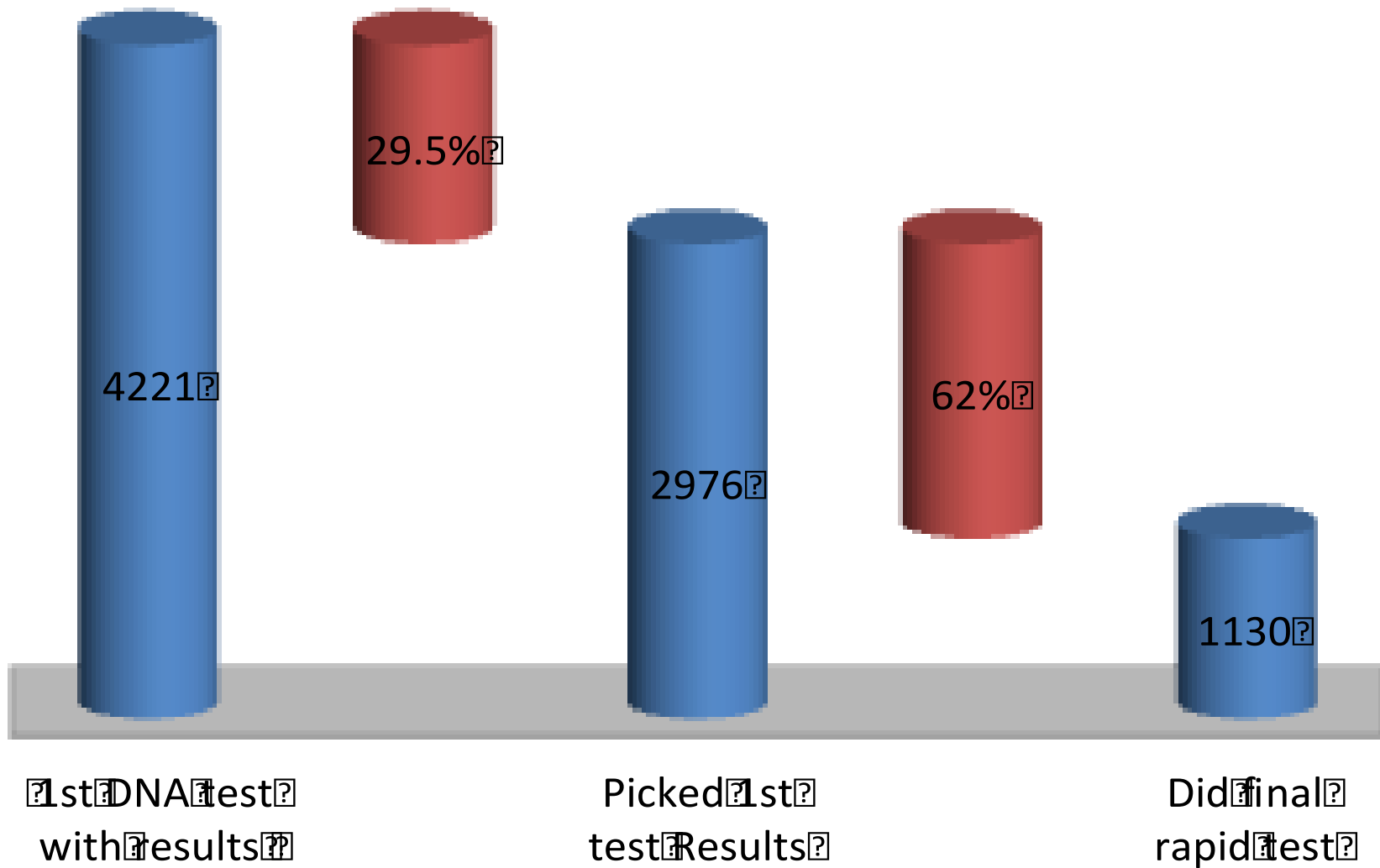
0 25 50 100 150 200 250 300



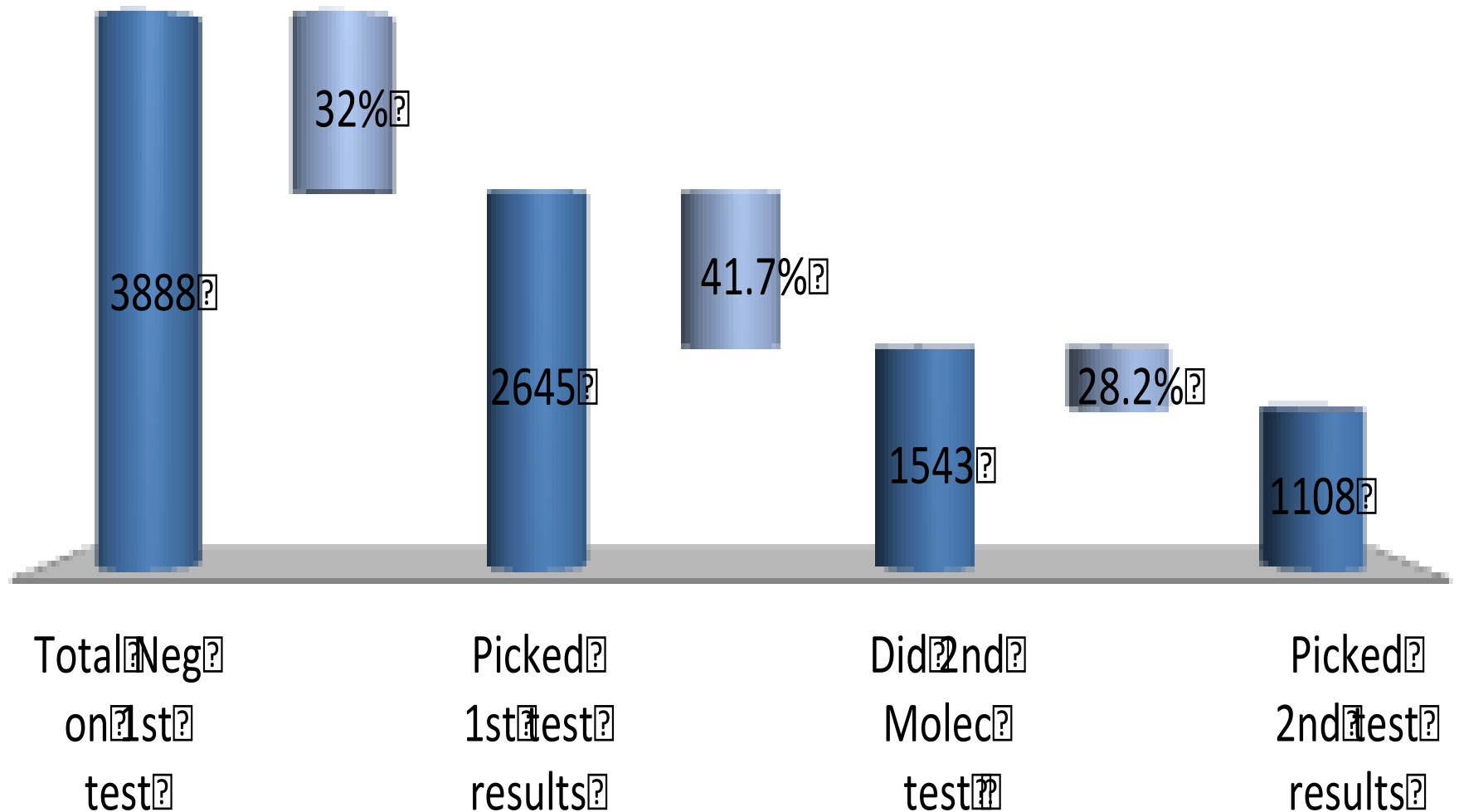
# Adherence to Testing Algorithm Flow Chart for the 24 Study Sites



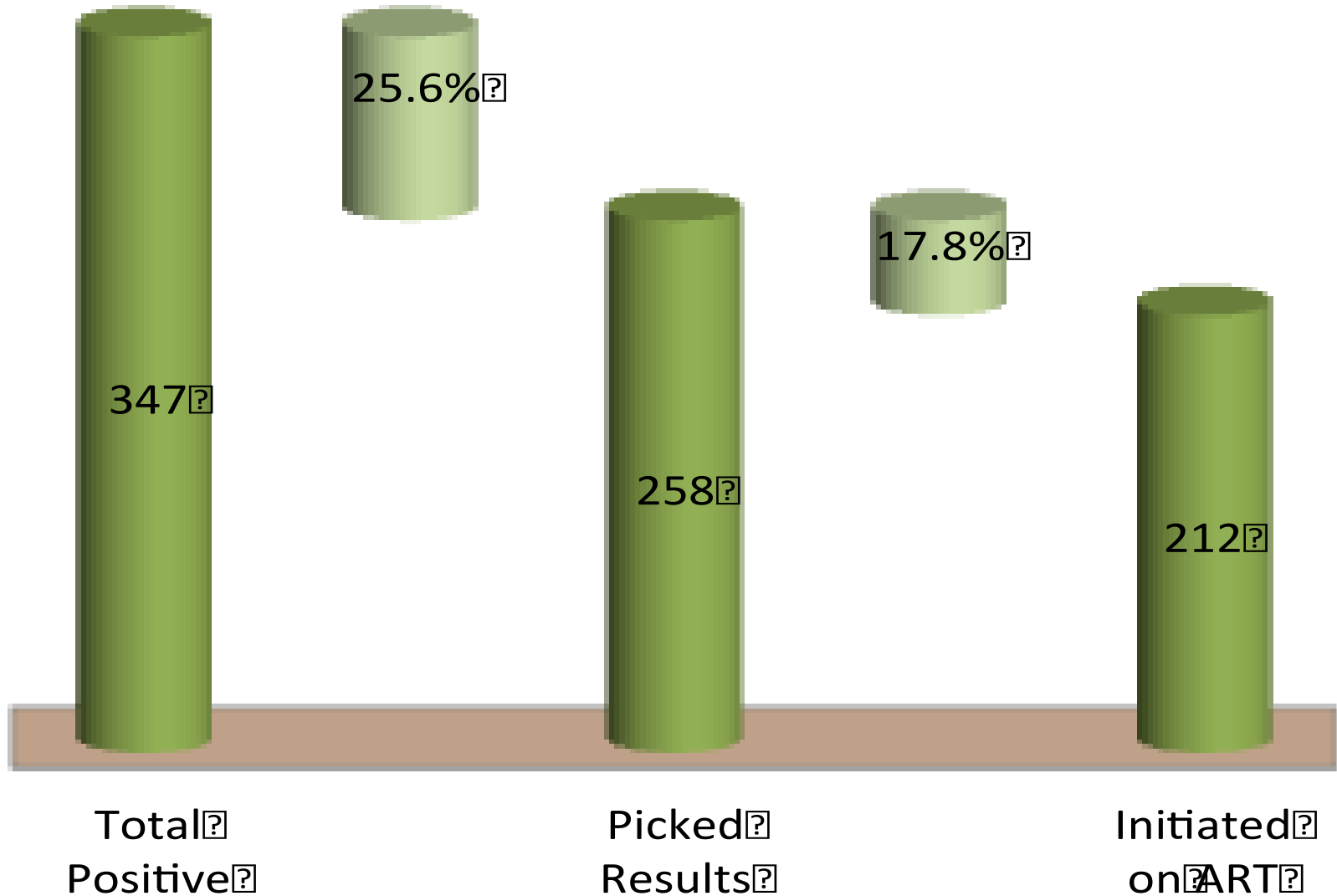
# Attrition from 1st PCR test to final HIV rapid test at all Study Sites stands at a cumulative loss of 73.2%



# Attrition for Negpts from 1st to 2nd PCR test at all study sites stands at a cumulative loss of 71.5%



# Attrition for Pospts from results to ART at all study sites stands at a cumulative loss of 38.9%

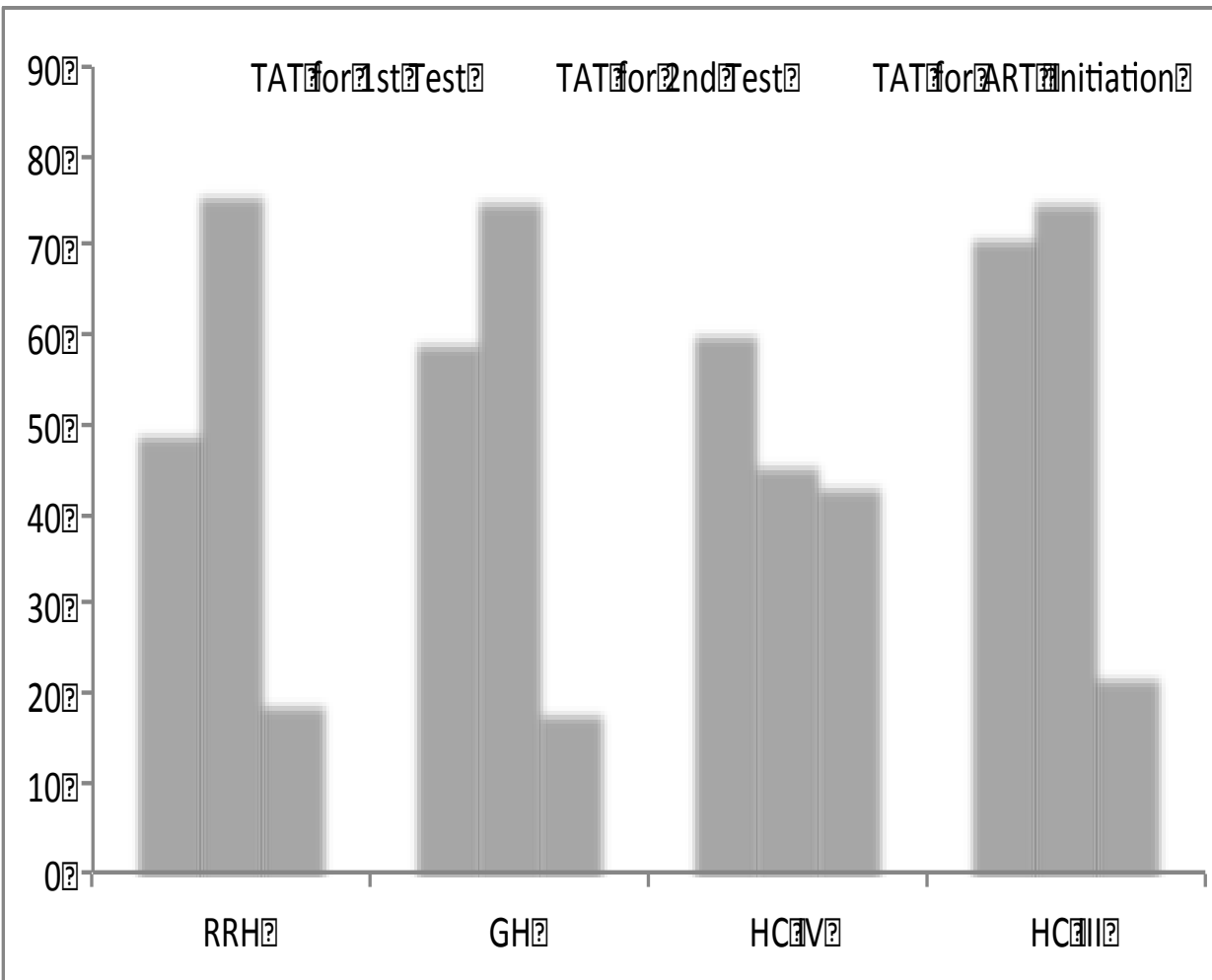




# Turn Around Time (TAT) in days for 1<sup>st</sup> and 2<sup>nd</sup> PCR test as well as ART initiation at the 24 study sites

TAT for T1 and T2 is from sample collection to when results are picked by the caretaker

TAT for ART Initiation is from when the caretaker receives positive results to when ART is initiated



- Average TAT for T1 is 60.2 days
- Average TAT for T2 is 68.3 days
- Average TAT for ART is 25.9 days
- Longest time is from result at site to when picked by client
- Why is TAT for T2 longer than for T1?
- TAT for ART initiation should be 0, why is it 25.9 days?

# Conclusions

- The uniqueness of EID is derived from the fact that the testing is not a one off, but a series over a period of time, which facilitates loss, as long as there are no mechanisms of patient follow up integrated into the testing process.
- Challenges of EID are not only a result of centralization or decentralization, and neither of these approaches by themselves may be able to resolve them alone.
- POC, though the hope of a new revolution in EID, may not be the magic bullet, if serious considerations are not made before their placement.
- It is one thing to have a testing algorithm and another thing to have the algorithm adhered to.

# Recommendations

- Seeing the results from this study portraying poor adherence to testing algorithm, similar programs should undertake equivalent assessments
- TAT is one of the major causes of loss at the different time points. Efforts to reduce TAT especially when results reach the facility should be made
- To improve adherence to the 2<sup>nd</sup> PCR test and the final Rapid test, patients may need to be reminded through telephone calls or other means.
- Because of poor adherence to testing algorithm, spot checks should be done to assess discordance, like what was done in Kenya by Kageha et al 2012.
- More capacity for Pead ART initiation should be built especially at lower level health facilities

# Recommendations

- There is need to integrated patient follow up and care into the EID testing process
- Due to the challenges with centralized EID programs, the same should be complemented with POC when they become available, especially in hard to reach areas and those that experience exceptionally long TAT.
- Before placement of POC, serious considerations should be made in order to optimize their impact.
- The considerations to be made should include; where POC should be placed, who should use it, what should be the patient flow, what should be the QA plan, what should be the data management plan, how should the logistics be managed, what about service and maintenance? etc.

END

Thank you for listening